SYMPTOM EVALUATION QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Do you have any of the following symptoms:

Facial pain (G50.1)	☐ Yes	☐ No
Jaw pain or discomfort (R68.84)	☐ Yes	☐ No
Neck pain (M54.2)	☐ Yes	☐ No
Headaches (R51)	☐ Yes	☐ No
Migraine headache (G43.109)	☐ Yes	☐ No
Bone loss/osteolysis (M89.58)	☐ Yes	☐ No
Nasal congestion or sinus problems (J32.0)	☐ Yes	☐ No
Muscle pain (masticatory muscle) (M79.11)	☐ Yes	☐ No
Muscle pain (auxiliary muscle, head and neck) (M79.12)	☐ Yes	☐ No
Muscle inflammation (M60.80)	☐ Yes	☐ No
Ringing in the ears – Tinnitus (H93.19)	☐ Yes	☐ No
Ear pain – Otalgia (H92.09)	☐ Yes	☐ No
Facial swelling (R22.0)	☐ Yes	☐ No
Sleep related (G47.33)	☐ Yes	☐ No

Other symptom(s): _____

_____

_____

_____

X _____ _____

Signature of Patient or Legal Guardian | Date