Date: \_\_\_/\_\_\_/\_\_\_\_\_\_ Pt # \_\_\_

**Dental Risk Factor Questionnaire/ Interview (5a)**

Interview by: RM BH LG SZ WA KS JB BB MM

To discover the possible causes and treatment of your jaw problem, we need the following questions answered. Please fill in the blanks and circle the answers that apply best to you. Most questions prompt a “yes” or “no”. If you don’t know an answer, we encourage you to seek help from a family member or your doctor. If you still can’t answer the question place a “?” mark in the margin.

1. **Dental Pain:** [Doctors: Use Timeline (5b) to illustrate chronology of important risk factors.]
   1. Do you have gum disease? Yes No
   2. Is your gum disease severe? Yes No

Do your gums bleed easily while tooth brushing? Yes No

* 1. Do (did) you have many loose teeth? Yes No

More than 13? Yes No

* 1. Besides wisdom teeth, do you have missing teeth? Yes No

Do you have 6-12 teeth missing Yes No

Do you have greater than 13 teeth missing? Yes No

* 1. Do you have active decay or infection in any of your

teeth now? Yes No

Do any of your teeth ache? Yes No

1. Do you tend to delay having your dental infections

taken care of? Yes No

1. Do these infections respond to antibiotics? Yes No

Do the dental infections clear up with root canal treatments? Yes No

1. Did the pain improve when you had a shot of Novocain? Yes No

1. Did you have a dental implant to replace a missing tooth? Yes No

Did the implant have to be removed? Yes No

1. Has your jaw had trouble healing after a dental extraction? Yes No
2. Do you have bad breath (halitosis)? Yes No
3. Have you had “dry sockets” after a dental extraction? Yes No
4. Do you wear dentures? Yes No
5. Is your denture for the upper jaw? Yes No
6. Is your denture for the lower jaw? Yes No
7. Does your dentist check your denture regularly? Yes No
8. Does your denture(s) feel loose? Yes No
9. Do you use a dental adhesive to secure them? Yes No

**Patient’s Dental Pain Score/Maximum Score Possible [ /24]**

1. **Jaw Pain:**
   1. Do you have a “nasty” taste in your mouth? Yes No

Can you tell where it is coming from? Yes No

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Do you have jaw pain now? Yes No

* 1. Is your jaw pain severe? Yes No
  2. Did your jaw pain get worse after root canal treatments? Yes No
  3. Did your jaw pain get worse after antibiotic therapy? Yes No
  4. Did you ever have an infection in your jaw bone? Yes No

When? \_\_\_/\_\_\_/\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Do your gums or face swell periodically? Yes No

* 1. Have you ever had a fractured jaw? Yes No
  2. Have you ever had corrective jaw surgery for orthodontics? Yes No
  3. Have you been told you might have osteonecrosis of the jaw? Yes No
  4. Do you have chronic pain in your upper jaw? Yes No
  5. Do you have chronic pain in your lower jaw? Yes No
  6. Was unexplained dentalpain the first symptom that you had? Yes No

(If Yes, please explain—use opposite side of this page, if

necessary.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Circle what treatment(s) your received?

Dental fillings root canals extractions

bone curettage bone resection steroids

IV antibiotics oral antibiotics hyperbaric oxygen

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you receive any one of the above treatments? Yes No

Did you receive any two of the above treatments? Yes No

Did you receive any three of the above treatments? Yes No

Did you receive more than three of the above treatments? Yes No

* 1. Did any of these treatments make your pain worse? Yes No

Which treatments did? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Was *unexplained jawbone* pain in the first symptom that you

experienced? Yes No

If Yes, please explain—use opposite side of this page if necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* 1. Circle any treatment(s) you received:

Dental fillings root canals extractions

bone curettage bone resection steroids

IV antibiotics oral antibiotics hyperbaric oxygen

removal of dental implants stop wearing dentures Other(s) \_\_\_\_\_\_\_\_\_\_\_

* 1. Did you receive any one of the above treatments? Yes No

Did you receive any two of the above treatments? Yes No

Did you receive any three of the above treatments? Yes No

Did you receive more than three of the above treatments? Yes No

* 1. Did any one of the treatments help your pain? Yes No

Did any two of the treatments help your pain? Yes No

Did any three of the treatments help your pain? Yes No

Did more than three of the treatments help your pain? Yes No

* 1. Which ones helped?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Do you have a history of jaw pain that your dentist says is

Not related to your teeth? Yes No

* 1. Do you have a history of atypical facial pain or

Trigeminal neuralgia? Yes No

Were you treated with steroids? Yes No

Were you treated with steroids on more than 5 occasions? Yes No

* 1. Have you been diagnosed with osteonecrosis of the jaw (ONJ)? Yes No

When? \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ By which doctor? \_\_\_\_\_\_\_\_\_\_\_\_

* 1. Did your doctor(s) struggle for more than 2 months before the

diagnosis of ONJ was made? Yes No

* 1. Were the treatment(s) that you had for your ONJ the same

as what you received for questions #13 #16 above? Yes No

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**Dental Pain Score/Maximum Possible Score [ /24]**

**Jaw Pain Score/Maximum Possible Score [ /35]**

**Total Dental Score/Maximum Possible Score [ /59] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**