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ORAL & MAXILLOFACIAL SURGERY

TRAUMA QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | **DO NOT WRITE IN THIS SPACE**

I. Name:_____ Date:_____
Date of trauma: _____
Was your trauma from:
Auto accident? _____ Fight? _____
Other? _____

How did the trauma happen? _____
_____
_____
_____

II. Make of your car?_____ Other vehicle_____
Speed of your car? _____ Other vehicle_____
Were you the driver? _____
Passenger? Front seat? _____ Back seat? _____
Other? _____

Were you wearing a seat belt? _____
Shoulder strap? _____
Did you have a head rest? _____ Air bag? _____
What did you strike? Windshield?_____
Steering wheel? _____Dashboard? _____
Other? _____

III. During the trauma did you strike your:
Skull? _____ Face around nose? _____
Lower jaw? _____ Neck? _____ Chest? _____

Did you have whiplash? _____

Did you have cuts? _____ Abrasions? _____
Bruises? _____
Bleeding from mouth? _____
Bleeding from nose? _____
Bleeding from ears? _____

IV. Were you knocked out:
Seconds? _____ Minutes? _____
Hours? _____ Days? _____
What is your first memory after the trauma? _____
_____

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TRAUMA QUESTIONNAIRE PAGE 2

PATIENT NAME: | **DO NOT WRITE IN THIS SPACE**

V. Immediately after the trauma, were you seen and treated at an:

Emergency room? _____
Name

Doctor's office? _____
Name

Other? _____
Name

When were you first seen for evaluation after the trauma?_____

_____

VI. Did you have x-rays of your skull? _____
Face? _____ Neck? _____ Other? _____
Did you have a CT scan? _____
Other tests? _____

VII. Where did you first hurt? _____
When did you first notice? _____
Headache? _____ Neck pain? _____
Jaw pain? _____ Ear pain? _____
Jaw joint noises? _____

Before the trauma, had you ever noticed:
Headache? _____ Neck pain? _____
Jaw pain? _____ Ear pain? _____
Jaw joint noises? _____
Pain with chewing? _____
Jaw locking? _____

VIII. Before this trauma, had you ever received any other injury:
Face? _____ Head? _____
Neck? _____
What type? _____

Other car accidents? _____ When? _____

IX. List all doctors who have treated you for this trauma and explain what they have done:

Emergency physician: _____

_____

Family doctor: _____

_____

Dentist: _____

_____

PATIENT NAME:

DO NOT WRITE IN THIS SPACE

Oral surgeon: _____

_____

Orthopedic surgeon: _____

_____

Neurologist: _____

_____

Neurosurgeon: _____

_____

Chiropractor: _____

_____

Psychologist/psychiatrist: _____

_____

Physical therapist: _____

_____

Other: _____

_____

Other: _____

_____

X. I have completed the above to the best of my knowledge and I personally have filled out each blank in my own handwriting.

_____

Signature

_____

Date