Veterans Affairs Canada | Anciens Combattants Canada

**Protected information when completed.**

| File No.: | Decision No.: |
|---|---|
| | Service No(s).: |

## Medical Questionnaire: Dental and Oral Conditions

| Family name: | Given name: | Date of Birth: |
|---|---|---|
| Name of Phvsician: | | Date of Examination: |

**MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:**

1. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

2. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

3. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

**Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.**

**Please complete applicable sections only.**

**If additional recording space is required, please use the "additional comments" sheet.**

**MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.**

Injuries? ◯ Yes ◯ No **Describe (include dates)**

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate the nature of the test/consultation, and the appointment date (if known).

**TMJ, Maxilla and Mandible:**

| | | |
|---|---|---|
| Does the client experience pain or discomfort? | ◯ Yes | ◯ No |
| If yes, specify the frequency (if applicable) | ◯ Occasional | ◯ Frequent to Constant |
| Does the client experience difficulty chewing? | ◯ Yes | ◯ No |
| Is a special diet required due to the TMJ condition? | ◯ Yes | ◯ No |

If yes, specify:

◯ permanent avoidance of some foods such as apples, corn, etc.
◯ permanent soft diet
◯ permanent pureed or liquid diet
◯ other, specify: _____

**Comments:**

| Family name: | Given name: | File No.: |
|---|---|---|

**Resting Joint Pain (applicable to TMJ conditions only):**

Does the client experience TMJ pain during the night every night? ◯ Yes ◯ No

If yes, please complete the following questions:

Does the resting joint pain interfere with sleep? ◯ Yes ◯ No

Does the resting joint pain respond to therapeutic measures such as medication, hot and cold applications, etc.? ◯ Yes ◯ No

Has the client attended a pain management program? ◯ Yes ◯ No

Please comment on response to treatment:

**PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)**

**TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).**

**COMPLICATIONS:**

Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No

If yes, please provide details:

**PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))**

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

**GENERAL APPEARANCE:**

Is there disfigurement due to a mandible/maxilla condition(s)? ◯ Yes ◯ No

If yes specify: ◯ mild ◯ severe

**Comments:**

**EXAMINATION FINDINGS: Describe any relevant examination findings.**

If applicable, identify tooth/teeth lost:

If applicable, describe any gingival or peridontal disease present:

**Comments:**

Inter-incisal range: ◯ not applicable ◯ 20 mm or less ◯ 21 - 25 mm ◯ greater than 25 mm

**Other Findings/Comments:**

| Family name: | Given name: | File No.: |
|---|---|---|

**OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)**

**Additional Comments:**

| Physician/Dentist's signature: | Is VAC to be invoiced? ◯ Yes ◯ No | Telephone No. ( ) | Today's date: |
|---|---|---|---|