STAB - Backward Translation

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STAB –
Standardized Tool for the Assessment of Bruxism

Demographic Data

Sex
Male
Female
Non-specified / Other

Age	Height	Weight

Marital Status:

( ) Married
( ) Living as married
( ) Divorced
( ) Separated
( ) Widow
( ) Never married

What is the highest degree or level of education that you have obtained?

( ) Elementary School (1st cycle) (1st-4th year)
( ) Middle School (2nd and 3rd cycles) (5th-9th year)
( ) High School (10th to 12th year)
( ) Bachelor's degree
( ) Master degree
( ) Doctoral degree
( ) Other: Which?_____

PORTUGUESE (PORTUGAL)
TRANSLATION PROJECT

AXIS A – ASSESSMENT OF BRUXISM STATUS AND CONSEQUENCES

Subject Based Assessment (SBA)—Self Report

A1. SLEEP BRUXISM REPORT

A1.1 Question about sleep bruxism

During the last month, how often do you clench or grind your teeth when asleep (based on any information you may have)?

( ) None of the time
( ) Less than one night/month
( ) 1-3 nights/month
( ) 1-3 nights/week
( ) 4-7 nights/week
( ) Do not know

A1.1.1 Question about history of sleep bruxism

In the past, did you clench or grind your teeth when asleep (based on any information you may have)?

( ) No
( ) Yes
( ) Do not know

A2. AWAKE BRUXISM REPORT

A2.1 Question about awake teeth grinding (awake time)
How often do you grind your teeth during waking hours, **based on the last month?**

( ) None of the time
( ) Rarely
( ) Some of the time
( ) Most of the time
( ) All the time
( ) Do not know

A.2.1.1 Question about awake teeth grinding history (awake time)

Did you use to grind your teeth during waking hours **in the past?**

( ) No
( ) Yes
( ) Do not know

A2.2 Question about teeth clenching on awakening (awake time)

How often do you **clench your teeth during waking hours**, based on the last month?

( ) None of the time
( ) Rarely
( ) Some of the time
( ) Most of the time
( ) All the time

( ) Do not know

A2.2.1 Question about teeth clenching on awakening (awake time)
Did you use to clench your teeth during waking hours in the past?

( ) No
( ) Yes
( ) Do not know

A2.3 Question about tooth contact while awake (awake time)
How often do you press, touch, or hold your teeth together other than while eating (that is, the contact between upper and lower teeth), based on the last month?

( ) None of the time
( ) Rarely
( ) Some of the time
( ) Most of the time
( ) All the time
( ) Do not know

A2.3.1 Question about dental contact while awake (awake time)
How often do you press, touch, or hold your teeth together other than while eating (that is, the contact between upper and lower teeth) in the past?

( ) No
( ) Yes
( ) Do not know

A2.4 Question about pressing or mandibular muscular tension without dental contact on awakening
Com **base no último mês, com que frequência sente um aumento da tensão muscular** você segura, aperta ou tensiona os músculos **sem apertar ou unir os dentes**?
How often do you hold, tighten, or tense your muscles without clenching or bringing teeth together, based on the last month?

( ) None of the time
( ) Rarely
( ) Some of the time
( ) Most of the time
( ) All the time
( ) Do not know

A2.4.1 Question about history of bracing or muscular mandibular tension without dental contact while awake
Did you use to hold, tighten, or tense your muscles without clenching or bringing teeth together in the past?

( ) No
( ) Yes
( ) Do not know

A3. PATIENT'S COMPLAINTS

TEMPOROMANDIBULAR DYSFUNCTION

A3.1 TMD-related pain
Nos últimos 30 dias, qual das seguintes opções melhor descreve qualquer dor na mandíbula ou região da fonte, de

ambos os lados?

In the last 30 days, what following options better describe any pain in your mandible or temple region on either side?

( ) No pain
( ) Pain comes and goes
( ) Pain is always present

A3.2 Pain or stiffness on awakening

In the last 30 days, have you felt pain or stiffness in your mandible on awakening?

( ) No
( ) **Yes**

A3.3 Closed lock

In the last 30 days, have you felt your jaw locked or caught, even for a moment, so it would not open ALL THE WAY?

( ) No
( ) **Yes**

A3.4 Pain change with activities

Nos últimos 30 dias, as seguintes atividades alteraram qualquer dor (isto é, aliviaram-na ou tornaram-na pior) na mandíbula, na fonte[JF1], no ouvido ou à frente do ouvido em algum dos lados?

In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your mandible, temple, ear, or in front of the ear on either side?

A. Chewing hard or tough food
( ) No
( ) Yes

B. Opening your mouth or moving your mandible forward or to the side
( ) No
( ) Yes

C. Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum
( ) No
( ) Yes

D. Other jaw activities such as talking, kissing, or yawning
( ) No
( ) Yes

A3.5 Articular Noises

In the last 30 days, have you felt any jaw joint noise (or noises) when you moved or used your mandible?

( ) No
( ) Yes

A3.6 Muscular pain on awakening

In the last 30 days, did you felt muscle pain in the jaws during any of the following times of the day?

( ) Between waking up and taking breakfast
( ) Between breakfast and lunch
( ) Between lunch and dinner
( ) Between dinner and bedtime

A3.6.1 Muscle tiredness or fatigue during waketime

In the last 30 days, did you feel muscle stiffness or sensation of muscular tension, tiredness or fatigue during any of the following times of the day?

( ) Between waking up and taking breakfast
( ) Between breakfast and lunch
( ) Between lunch and dinner

( ) Between dinner and bedtime

A3.7 Question about symptoms upon awakening

Are you aware of any of the following symptoms upon awakening?

( ) Sensation of fatigue, soreness or tightness of your jaws
( ) Feeling that your teeth are clenched or that your mouth is sore
( ) Pain in the temples
( ) Feeling of tension in your jaw joint upon awakening and feeling that you have to move your lower jaw to release it
( ) Difficulty in opening mouth wide upon awakening
( ) Hearing or feeling a click in your jaw joint upon awakening that disappears afterwards

HEADACHES

A3.8 Headaches

In the past 30 days, have you had any headache that included the temple areas of your head?

( ) No
( ) Yes
If yes, how many days? _____

TOOTH WEAR

A3.9 Tooth wear

Do you experience any of the following symptoms because of the existing tooth wear?

( ) Sensitivity and/or pain
( ) Functional problems (difficulties chewing and eating)
( ) Deterioration of esthetic appearance (compromised dental attractiveness)
( ) Damage of the dental hard tissue and restorations
( ) Phonetic impairment

ACUFENOS

A3.10 Tinnitus

Do you have noises or ringing in your ears (tinnitus)?

( ) No
( ) Yes

XEROSTOMIA AND DROOLING

A3.11 Xerostomia

Does **your mouth feel dry**?

( ) Never
( ) Occasionaly
( ) Very often

A3.12 Drooling

Do you experience loss of saliva during sleeptime?

( ) I do not experience loss of saliva during the night at all
( ) My pillow sometimes gets wet during sleeptime
( ) My pillow regularly gets wet during sleeptime
( ) My pillow always gets wet during sleeptime
( ) Every night my pillow and other bedclothes get wet

Avaliação Baseada na Análise Clínica (CBA) – Relatório do examinador
Clinically based assessment (CBA) - Examiners report

(for examiner's use)

A4. JOINTS AND MUSCLES

A4.1 TMD diagnoses (optional item)
Mark the presence of the following diagnoses

A4.1.1. Perturbações da dor*

A4.1.1. Pain disorders*

*Please fill this section only if the item A3.3 (TMD Pain Screener Questionnaire) is positively endorsed by the patient

( ) Myalgia
( ) Myofascial pain with spreading
( ) Myofascial pain with referral
( ) Right arthralgia
( ) Left arthralgia
( ) Headache attributed to TMD

A4.1.2. Right TMJ disorders*

*Please specify if diagnosis is based upon clinical or/and imaging assessment

Disc displacement with reduction
Disc displacement with reduction, with intermittent locking
Disc displacement without reduction with limited opening
Disc displacement without reduction without limited opening
Degenerative joint disease
Subluxation

A4.1.3. Left TMJ disorders*

Please specify if diagnosis is based upon clinical or/and imaging assessment

Disc displacement with reduction

Disc displacement with reduction, with intermittent locking
Disc displacement without reduction with limited opening
Disc displacement without reduction without limited opening
Degenerative joint disease
Subluxation

A4.2 Masseter muscle hypertrophy
Mark the presence of masseter hypertrophy
( ) Left
( ) Right

A5. INTRA- AND EXTRA-ORAL TISSUES

A5.1 Soft tissues and bones

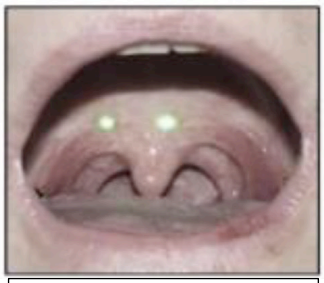
Mark the presence of the following signs, drawing a circle around the correct answer:

Linea Alba	Left	Right	
Edentations in the lip	Upper	Lower	
Tongue edentations	Right	Front	Left
Ulcers in the tongue*	Right	Front	Left
Alveolar bone exostosis	Mandible (buccal/lingual)	Maxilla (buccal/palatal/palatal midline)	

*If positive and it has firm, indurated, and raised borders – red flag for further urgent investigation

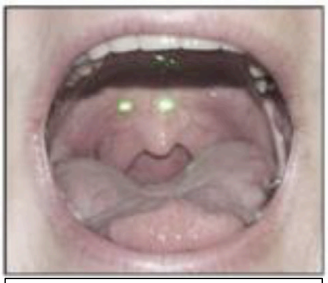
A5.2 Tongue position - Modified Friedman Classification

After intra-oral evaluation, mark the respective category



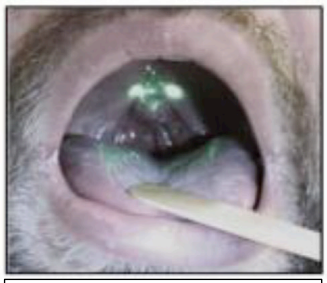
Category I:
Absence of phonation, tongue depressor – uvula and palatal arch visible

( )



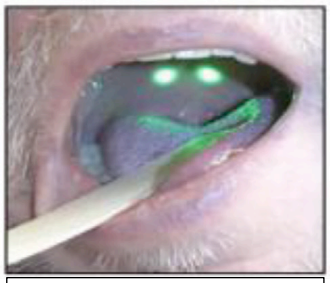
Category II:
With phonation – uvula and palatal arch visible

( )



Category III:
With tongue depressor – uvula and palatal arch visible

( )

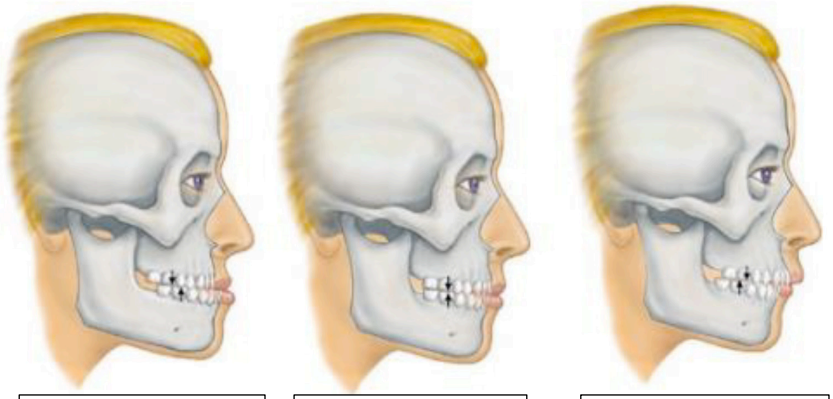


Category IV:
With phonation and tongue depressor – uvula and palatal arch not visible

( )

A5.3 Skeletal Class (optional item)

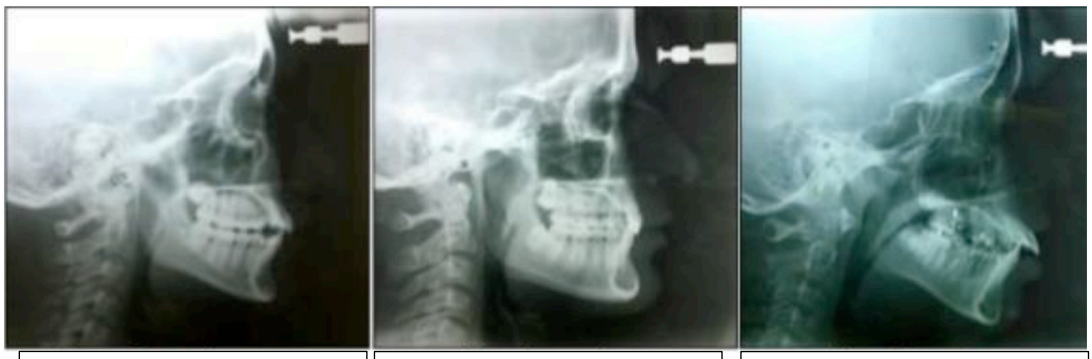
( ) Class I
( ) Class II
( ) Class III



Skeletal Class III Facial Profile	Skeletal Class I Facial Profile	Skeletal Class II Facial Profile

A5.4 Skeletal Profile (optional item)

( ) Normodivergent profile (medium gonial angle)
( ) Hypodivergent profile (low gonial angle)
( ) Hyperdivergent profile (high gonial angle)



Normodivergent	Hipodivergent	Hiperdivergent

A6. TEETH AND RESTORATIONS

A6.1 Screening for tooth wear – quantification

a. Occlusal/incisal wear score per sextant

(0) no visible wear

(1) visible wear inside the enamel

(2) visible wear with exposure of dental and ≤1/3 loss of clinical crown height

(3) loss of crown height >1/3 but <2/3

(4) loss of crown height ≥2/3

b. Palatal wear in the 2nd sextant

(0) no visible wear, (1) visible wear in the enamel, (2) visible wear in dentin

1st Sextant - Occlusal	2nd Sextant - Incisors	3rd Sextant - Occlusal
0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2nd Sextant - Palatal	
	0 1 2	
6th Sextante - Occlusal	**5th Sextant - Incisors**	**4th Sextant - Occlusal**
0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

A.6.1.1 Qualification for tooth wear*

*When during quantification a grade ≥ 2 is detected, quantification is needed.

Clinical signs indicating the influence of mechanical factors:

Shiny facets, flat and glossy
Enamel and dentin wear at the same rate
Matching wear on occluding surfaces, corresponding features at the antagonistic teeth Fracture of cusps or restorations
Impressions in cheek, tongue and/or lip
Located at cervical areas of the teeth, Non Carious Cervical Lesions (NCCL) Buccal/cervical lesions more wide than deep, Non Carious Cervical Lesions (NCCL) Cervical areas of premolars and cuspids are affected
Cracks within the enamel
Torus mandibulae

a. The observed tooth wear is:

☐ Mainly mechanic

☐ Mainly chemical

☐ Mechanical and chemical

A6.2 Periodontal and Dental Exam

Mark the number of the tooth that have the following signals:

	1º Sextant	2º Sextant	3º Sextant	4º Sextant	5º Sextant	6º Sextant
Dental Mobility						
Thermal						

sensitivity						
Disconfort/pain when biting						
Fractured teeth						

A6.3 Restoration

Mark the number of the teeth/implants that have the following signals

	1º Sextant	2º Sextant	3º Sextant	4º Sextant	5º Sextant	6º Sextant
Lost/broken fillings						
Erodes/Worn down restorations						
Ceramic Fractures (shipping??)						
Implant Mobility						
Implant fracture						
Fracture/Loosening of screws in restorations over implants						

A6.4 Intra-oral appliance evaluation (if hard acrylic resin splint is used by the patient)
Mark the presence of the following signals

	Right	Anterior zone	Left
Prevalence of grinding marks (horizontal stripes...)			
Prevalence of clenching marks (circle-like spots on the acrylic)			
Combination of grinding			

and clenching marks			
Fractures or perfurations			

Assessment Based on the Information from Technological Instruments

A7. Sleep bruxism

A7.1 Electromyography

Number of masseter events over 10% MVC	————
Bruxism time index (if available)	————
Bruxism work index (if available)	————

A7.2 Polysomnography (optional)

Number of arousal-related SB events	————
Number of arousal-unrelated SB events	————
Bruxism time index (if available)	————
Bruxism work index (if available)	————

A7.3 Other methods (optional)

Punctuation in the application for smartphone relative to the tooth grinding noises:_____

A7.4 Appliance with sensors (optional)

Number of events of increased pressure associated with tooth clenching:_____

A8. AWAKE BRUXISM

A8.1 Ecological momentary assessment – one week report monitoring

Condição	1 week (in %)	Additional Week(s) (in %)
Relaxed jaw muscles (no tooth contact)		
Muscular tension and sensation of mandibular pressure (without tooth contact)		
Teeth Contact (light steady touching)		
Teeth clenching (strong and steady)		
Teeth grinding		

A8.2 Wake-time electromyography

Number of masseter events over 10% MVC (maximum voluntary contraction): _____

Bruxism time index (if available):_____

Bruxism work or behavior index (if available):_____

A8. ADDITIONAL INSTRUMENTS

A9.1. Intraoral acidity (opcional)
pH saliva at rest: _____
salivary flow at rest: _____
pH saliva after stimulation (parafin): _____
Stimulated salivary flow: _____

AXIS B – ETIOLOGICAL FACTORS E ASSOCIATED COMORBIDITIES[JF2]

B1. PSICOSSOCIAL ASSESSMENT — SELF-REPORT

B1.1 Anxiety and Depression Screening

In the last two weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious or on edge
   ( ) Never
   ( ) Several days
   ( ) More than half the days
   ( ) Nearly every day

2. Not being able to stop or control worrying:
   ( ) Never
   ( ) Several days
   ( ) More than half the days
   ( ) Nearly every day

3. Little interest or pleasure in doing things
   ( ) Never
   ( ) Several days
   ( ) More than half the days
   ( ) Nearly every day

4. Feeling down, depressed, or hopeless
   ( ) Never
   ( ) Several days
   ( ) More than half the days
   ( ) Nearly every day

B1.2 *Coping*

Consider how well the following statements describe your behaviors and actions

1. I looking for creative ways to alter difficult situations
   ( ) Does not describe me at all
   ( ) Does not describe me
   ( ) Neutral
   ( ) Describes me
   ( ) Describes me very well

2. Regardless of what happens to me, I believe I can control my reaction:
   ( ) Does not describe me at all
   ( ) Does not describe me
   ( ) Neutral
   ( ) Describes me
   ( ) Describes me very well

3. I believe I can grow in a positive way by dealing with difficult situations
   ( ) Does not describe me at all
   ( ) Does not describe me
   ( ) Neutral
   ( ) Describes me
   ( ) Describes me very well

4. I actively look for ways to replace the losses I encounter in life
   ( ) Does not describe me at all
   ( ) Does not describe me
   ( ) Neutral
   ( ) Describes me
   ( ) Describes me very well

B2. CONCOMITANTES ASSESSMENT OF CONCURRENT SLEEP-RELATED CONDITION – SELF-REPORT

B2.1 Sleep apnea screening

Please mark which of the following questions is answered positively:

( ) Do you snore loudly?
( ) Do you often feel tired, fatigued or sleepy during daytime?
( ) Has anyone observed you stop breathing or choking/gasping during sleep?
( ) Do you have or are being treated for high blood pressure?
( ) Tem índice de massa corporal superior a 35 (peso/altura^2)?Do you habe a body mass more than 35 (weight/height$^{2)}$?
( ) Age older than 50?
( ) Perímetro do pescoço elevado (43cm ou maior para os homens; 41cm ou maior para as mulheres)? Neck size large (43 cm or larger for males; 41 cm or larger for females)?
( ) Male = female?

B2. Insomnia screening

Indicate which of the following statements can be applied to you:

( ) I have difficulty falling asleep
( ) Thoughts race through my mind and prevent me from sleeping
( ) I anticipate a problem with sleep several times a week
( ) I wake up and cannot go back to sleep
( ) I worry about things and have problems relaxing
( ) I wake up earlier in the morning than I would like to
( ) I lie awake for half an hour or more before I fall asleep

B2.3 Periodic limb movement disorder and restless leg syndrome screening

Indicate which of the following statements can be applied to you?
( ) Other than when exercising, I still experience muscle tension in my legs
( ) I have noticed (or other have commented) that parts of my body jerk during sleep
( ) I have been told that I kick at night
( ) When trying to go sleep, I experience an aching or numbness sensation in my legs
( ) I experience leg pain and cramps at night
( ) Sometimes I can't keep my legs still at night. I just have to move them to feel comfortable
( ) Even though I slept during the night, I feel sleepy during daytime (while awake)

B2.4 Oral behaviors – sleep position

How often do you sleep in a position that puts pressure on the mandible, based on the last month?
( ) None of the time
( ) Rarely
( ) Some of the time
( ) Most of the time
( ) All the time
( ) Do not know

B3. ASSESSMENT OF CONCURRENT NON-SLEEP CLINICAL CONDITIONS - SELF-REPORT

B3.1 Oral behaviors – activities during awake time

How often do you do each of the following activities, based on the last month?

Activities during the day | None of the time/A little of the time/Some of the time/Most of the time/All of the time/All the time
7. Hold or jut jaw forward or to the side
8. Press tongue forcibly against teeth
9. Place tongue between teeth
10. Bite, chew or play with your tongue, cheeks or lips

11. Hold jaw in rigid or tense position, such as to brace or protect the mandible from impact
12. Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails etc
13. Use chewing gum
14. Play musical instrument that involves use of mouth or mandible (for example, wind instruments, metal or wood, or string instruments)
15. Lean with your hand on the jaw, such as cupping or resting the chin in the hand
16. Chew food on one side only
17. Eating between meals (that means food that requires chewing)
18. Talking for prolongued periods (for example, teaching, sales, customer services)
19. Singing
20. Yawning
21. Hold telephone between your head and shoulders

[JF3]

	Atividades durante o dia	Nenhuma vez	Um pouco do tempo	Algum do tempo	A maior parte do tempo	Todo o tempo
7.	Mantém ou projeta a mandíbula para a frente ou para o lado	☐	☐	☐	☐	☐
8.	Pressiona com força a língua contra os dentes	☐	☐	☐	☐	☐
9.	Coloca a língua entre os dentes	☐	☐	☐	☐	☐
10.	Morde, mastiga ou brinca com a sua língua, bochechas ou lábios	☐	☐	☐	☐	☐
11.	Mantém a mandíbula numa posição rígida ou tensa, como se fosse preparar para um impacto ou proteger a mandíbula	☐	☐	☐	☐	☐
12.	Mantém entre os dentes ou morde objetos, tais como, cabelo, cachimbo, lápis, canetas, dedos, unhas, etc.	☐	☐	☐	☐	☐
13.	Utiliza pastilha elástica	☐	☐	☐	☐	☐
14.	Toca instrumento musical que envolva o uso da boca ou mandíbula (por exemplo, instrumentos de sopro, metal ou madeira, ou instrumentos de corda)	☐	☐	☐	☐	☐
15.	Inclina-se com a mandíbula sobre a sua mão, por exemplo, em concha ou a descansar o queixo na mão	☐	☐	☐	☐	☐
16.	Mastiga a comida só de um lado	☐	☐	☐	☐	☐
17.	Come entre refeições (isto é, comida que requeira mastigação)	☐	☐	☐	☐	☐
18.	Fala durante períodos prolongados (por exemplo, ensina, vende, apoio ao consumidor)	☐	☐	☐	☐	☐
19.	Canta	☐	☐	☐	☐	☐
20.	Boceja	☐	☐	☐	☐	☐
21.	Segura o telefone entre a sua cabeça e os ombros	☐	☐	☐	☐	☐

B3.2 Smartphone use or other electronic appliances (optional item)

Indicate the average time per day, in hours, of smartphone use or other electronic appliances: _____ h

B3.3 Distúrbios motores orofaciais Orofacial motor disorders

Foi diagnosticado ou sofre de possíveis sinais de alguma das condições seguintes?

( ) Discinesia Orofacial
( ) Distonia Oromandibular
( ) Doença de Parkinson
( ) Doença de Huntington
( ) Síndrome de Tourette

( ) Espasmos Hemifaciais
( ) Discinesia tardia
( ) Orofacial Dyskinesia
( ) Oromandibular Dystonia
( ) Parkinson's Disease
( ) Huntington's Disease
( ) Tourette's Syndrome
( ) Hemifacial Spasms
( ) Tardive Dyskinesia

B3.4 Gastroaesophageal reflux disease screening

How many times per week do each of the following symptoms occur?

A. Burning feeling behind the breastbone (heartburn)
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

B. Stomach contents moving up to the throat or mouth (regurgitation)
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

C. Pain in the middle or upper stomach area
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

D. Nausea
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

E. Trouble getting a good night's sleep because of heartburn or gastric reflux
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

F. Need for medicine for heartburn or gastric reflux
( ) 0 Days
( ) 1 Day
( ) 2–3 Days
( ) 4–7 Days

B3.5 Autoimmune or connective tissue disorders screening

Have you been diagnosed with one of the following conditions?

( ) Rheumatoid Arthritis
( ) Lupus
( ) Other systemic rheumatic diseases, including fibromyalgia
( ) Other systemic conditions, including systemic sclerosis, rheumatic polymyalgia, mixed connective disease

B3.6 Attention deficit hyperactivity disorder

Have you been diagnosed with Attention Deficit Hyperactive Disorder?
( ) No
( ) Yes

B4. PRESCRIBED MEDICATIONS AND ASSESSMENT OF THE USE OF SUBSTANCES - SELF-REPORT

B4.1 Drugs

Do you use recreational or illicit drugs?
( ) No
( ) Yes

If yes, please state which drugs do you consume: _____

B4.2 Medications

Are you currently taking any of the following medications?
( ) Antidepressants (for example, Selective serotonin-reuptake inhibitors)
( ) Benzodiazepines
( ) Neuroleptics, Antipsychotics, Antiemetics (Dopamine antagonists)
( ) ADHD medication
( ) Anti-allergic medication
( ) Medical marijuana CBD
( ) Medical marijuana TSH
( ) Opioids
( ) Others

If you selected any of the above options, please list all the medications and respective dosage:

_____

_____

_____

B4.3 Tobbaco

Do you smoke or use any tobacco product?
( ) No

( ) Yes
( ) Occasionally

If yes, how many cigarettes per day do you smoke? Number_____

B4.4 Alcohol

Do you ever drink alcoholic beverages (beer, wine, hard liquors, etc)?
( ) No
( ) Yes
( ) Occasionally

If yes, what is your approximate intake of these alcoholic beverages (glasses/day)? _____

B4.5 Soft drinks

Do you regularly drink sparkling drinks (e.g., Cola, RedBull, Fanta, Sprite, other soft drinks, etc)?
( ) No
( ) Yes
( ) Occasionally
If yes, what is your approximate intake (glasses/day)? _____

B4.6 Juices and fruits

Do you regularly drink juices or citric fruits (e.g., lemon, orange, grapefruit)?
( ) No
( ) Yes
( ) Occasionally

If yes, what is your approximate intake (glasses/day)? _____

B4.7 Cafeína

Do you regularly drink coffee, tea, or other caffeine beverages?
( ) No
( ) Yes
( ) Occasionally
If yes, what is your approximate intake (glasses/day)? _____

B5. ASSESSMENT OF ADDITIONAL FACTORS

B5.1 Familiar bruxism screening

Do you know of anyone in your family (for example, father, mother, children) who has had any history of bruxism?
( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Do not know

B5.2 Familiar tooth wear screening

Sabe de alguém na sua família (por exemplo, pai, mãe, filhos) que tenha desgaste dentário?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Do not know

B5.3 Familiar Obstructive Sleep Apnea screening

Do you know of anyone in your family (for example, father, mother, children) who has sleep apnea?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Do not know

B5.4 Familiar orofacial pain screening

Do you know of anyone in your family (for example, father, mother, children) who has non-dental orofacial pain?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Do not know

B5.5 Familiar GERD screening

Do you know of anyone in your family (for example, father, mother, children) who has gastroaesophageal reflux disease?

( ) No
( ) Yes Father/Mother/Son/Daughter/Grandfather/Grandmother
( ) Do not know