

CRANIOFACIAL PAIN/MEDICAL HISTORYCHIEF COMPLAINTS

1. Number your complaints with 1 being the most important and rate your complaints for frequency and intensity.

Frequency: 0. Never 1.Seldom 2. Occasional 3.Frequent 4. Daily

Intensity: 0. No pain 10. The most severe pain.

	Frequency	Intensity
<u>1: MOST IMPORTANT</u>	<u>0-4</u>	<u>0-10</u>
___ Back Pain	_____	_____
___ Dizziness	_____	_____
___ Ear Congestion.	_____	_____
___ Ear Pain	_____	_____
___ Eye Pain	_____	_____
___ Facial Pain	_____	_____
___ Fatigue	_____	_____
___ Headaches	_____	_____
___ Inability to Open Mouth	_____	_____
___ Jaw Clicking	_____	_____
___ Jaw Joint Noises	_____	_____
___ Jaw Pain	_____	_____
___ Limited Mouth Opening	_____	_____
___ Migraine Headaches	_____	_____
___ Muscle Twitching	_____	_____

OTHER ALLERGENS

MEDICATIONS CURRENTLY BIENG TAKEN.

Medication name, doses , quantity and frequency.

Antibiotics _____

Cortisone _____

Never pills _____

Anticoagulants _____

Diet pills _____

Pain Medication _____

Barbiturates _____

Heart medication _____

Sleeping pills _____

Blood thinners _____

Insulin _____

Sulfa drugs _____

Codeine _____

Muscle relaxants _____

Tranquilizers _____

OTHER MEDICATIONS

MEDICAL HISTORY

Adenoids Removed ____

Current pregnancy ____

General anesthesia ____

Tonsils Removed ____

Depression ____

Glaucoma ____

Anemia ____

Diabetes ____

Gout ____

Arteriosclerosis ____

Difficulty concentrating ____

Hay Fever ____

Asthma ____

Dizziness ____

Hearing impairment ____

Autoimmune Disorders ____

Emphysema ____

Heart disorder ____

Bleeding easily ____

Epilepsy ____

heart murmur ____

Blood Pressure:

Excessive Thirst ____

Heart disorder ____

High ____

Low ____

Bruising easily ____

Fibromyalgia ____

Heart pacemaker ____

Cancer ____

Fluid retention ____

Heart palpitations ____

Chemotherapy ____

Frequent cough ____

Heart valve replacement ____

Chronic Fatigue ____

Frequent illness ____

Hemophilia ____

Cold Hands & Feet ____

Frequent stressful situations ____

Hypoglycemia ____

Immune system disorder ____

Muscular dystrophy ____

Poor circulation ____

Injury to:

Needing extra pillows to

Prior orthodontic Treatment ____

Face ____ Mouth ____

help breathing at night ____

Psychiatric care ____

Neck ____ Teeth ____

Nervous system irritability ____

Radiation treatment ____

Insomnia ____

Nervousness ____

Rheumatic fever ____

Intestinal disorders ____

Neuralgia ____

Rheumatoid arthritis ____

Jaw joint surgery ____

Osteoarthritis ____

Scarlet Fever ____

Kidney problems ____

Osteoporosis ____

Shortness of breath ____

L R B Back of your head (Occipital) _____

L R B In Your Temples (Temporal) _____

JAW PAIN

L R B Jaw Pain- On opening

L R B Jaw Pain-While chewing

L R B Jaw Pain-when closing

JAW SYMPTOMS

Jaw click _____ Jaw locks closed _____ Jaw locks open _____

Jaw popping _____ Teeth clenching _____ Teeth grinding _____

EAR RELATED CONDITIONS

Buzzing in the ears Ear Congestion Pain behind the ear

Pain in front of the ear Recurrent ear infections Tinnitus (ringing in the ear)

EYE RELATED CONDITIONS

Blurred vision _____ Double Vision _____ Eye pain _____

Pain or pressure behind eyes _____ Photophobia (extreme sensitivity to light) _____

THROAT, NECK & BACK RELATED CONDITIONS

Back pain- lower _____ Back pain- middle _____ Back pain- upper _____

Chronic sore throat _____ Constant feeling of a foreign object in throat _____

Difficulty in swallowing _____ Limited movement of neck _____ Neck pain _____

Numbness in the hands / fingers _____ Sciatica _____ Scoliosis _____

Shoulder pain ____

Swelling in the neck ____

Swollen glands ____

Thyroid enlargement ____

Tightness in throat ____

Tingling in the hands/finger ____

Wryneck ____

PAIN HISTORY

Again what are your chief complaints (main concerns) listing the most important first? Date of Onset

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Are you in pain now? Yes No

On this pain scale of 1 to 10 (10 being most severe) place an 'X' on the scale indicating severity of your pain.

Worse Level 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Usual Level 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Current Level 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

DESCRIPTION OF PAIN: *(circle all that apply)*

A. Stabbing Sharp Bright Stimulating Raw

B. Shocking Piercing Burning Electric Lanciating

C. Dull Aching Deep Depressing Boring

D. Pulsating Throbbing Association with: Nausea / Vomiting / Aura / Dizziness

E. Spasm Tightness Stiffness Cramping Reduced Range of Movement

CHARACTERISTICS OF PAIN: (circle all that apply)

A. Pain Primarily: Right sided Left sided Both sides Varies

B. Intensity: Mild Moderate Moderate/Severe Severe

C. Onset of Pain: Gradual Sudden A.M. / P.M. Night

D. Duration of Pain: Intermittent Variable Constant Minutes Hours Days

E. Cessation of Pain: Gradual Sudden Always Same Decreases as day goes on

F. Pattern of Pain: Worse at Waking Worse at Night Increases as day goes on

Number of days per month with: headache _____ neck ache _____ tooth pain _____

How many types of headaches do you have? _____

Status of Pain: Increasing Decreasing Unchanged

What do you *think* is cause of your condition? _____

What starts or makes it worse? (stress, chewing, foods, weather, etc.) _____

What makes it better? (rest, medication, treatments, etc.) _____

Medication taken for this condition:

1. _____ Results _____

2. _____ Results _____

3. _____ Results _____

Relieved by: (circle) Antihistamines Antidepressants Antianxiety
 Aspirin / Tylenol Muscle Relaxers Codeine / Narcotics Cardiac / Blood Pressure
 MedsMigraine Meds

Are you willing to give your pain up? Yes No

Are you willing to do whatever it takes to manage this condition? Yes No

Does this condition interfere with your daily routine or interfere with the quality of you life?Yes No

How? _____

What do you believe is the cause of your pain condition?

- A motor vehicle accident. Date _____
- A motorcycle accident. Date _____
- A work-related incident. Date _____
- Playground incident. Date _____
- Athletic endeavor. Date _____
- Unknown. Date _____
- Other. Date _____

MOUTH AND NOSE RELATED CONDITIONS

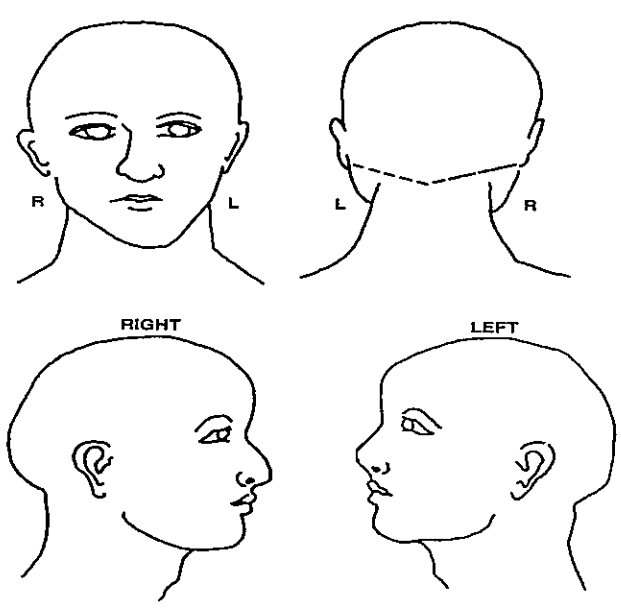
Broken teeth _____ Burning tongue _____ Chronic sinusitis _____
 Dry mouth _____ Frequent biting of cheek _____ Frequent snoring _____

OTHER SYMPTOMS

None____ Occasional____ Social Drinker ____ Daily ____

CHECK THE INTENSITY OF YOUR PAIN INSIDE OF THE PICTURE

- Mild: Mi
- Moderate: M
- Severe: S



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