ADVANCED ORAL AND FACIAL SURGERY OF THE MAIN LINE, PC
G. JOEL FUNARI, M.S., D.M.D.

Orofacial Pain Examination Form

Please complete pages 1 through 4.
Circle choices whenever available.

Name _____ **Date**_____

SSN _____ **DOB** _____ **Gender: M F**

Who referred you for this evaluation?

Describe your problem(s):
What is the nature of your problem?

When did it start?

What was the cause?

Do you have a history of injury or trauma?

Who have you seen for your pain problem(s)? Primary Care ENT Neurology Anesthesia-Pain Clinic Physical Therapy Dentist Chiropractor (Please provide names and phone numbers)

What types of treatment(s) have you received for you pain problem(s)?

Current and previous medication(s) used for your pain problem(s)?

What do you think needs to be done about your problem?

Personal/Family History

a. Occupation: _____
b. Marital status: Single Married Separated Divorced
c. Children: Y N If yes, list ages _____

d. Are there any special needs or circumstances involving you, your family members or your job? Y N

_____

e. Do you have any history of the following or other similar threatening, stressful or frightening life events?
Y N If yes, describe below
abuse - at any age (physical, emotional or sexual), childhood neglect, physical or sexual assault, near drowning, panic attacks, post-traumatic stress disorder, other

_____

_____

f. Exercise level: None Slight Moderate Active Any activity limitations? _____

What is your consumption of the following?

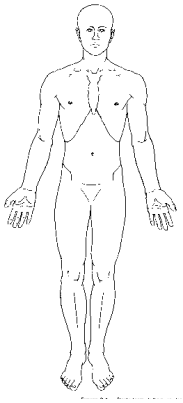
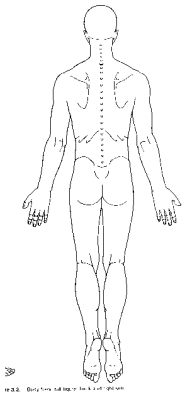
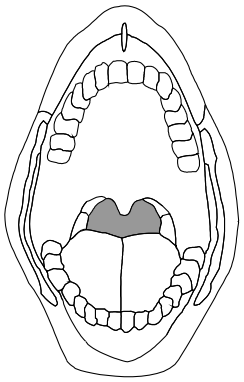
Nicotine Y N How long? _____ cigarettes _____/day cigars_____ pipe _____ snuff _____
Alcohol Y N beer _____ /day wine _____ glasses/day liquor _____ drinks/day
Caffeine Y N cups(cans)day _____ coffee tea soda chocolate
Water Y N glasses/day _____
Juice or milk Y N glasses/day _____
Vitamins Y N multivitamins _____ specific supplements _____
Is your diet? balanced high sugar high carbohydrate high fat
Do you routinely skip any meals? Y N Which? Breakfast Lunch Dinner
Any recent significant weight gain/loss? _____

Please rate your overall levels of:

	None		Worst possible
Stress	0_____	5_____	10
Anxiety	0_____	5_____	10
Depression	0_____	5_____	10
Anger	0_____	5_____	10

Have you ever thought of harming yourself? Yes No _____

Where is your pain? Draw the location(s) of <u>ANY</u> pain that you experience.

PATIENT NAME: ID NUMBER: DATE:

Circle which word(s) characterize your pain or pains?
Sharp Burning Electric-like Aching Throbbing Dull Pulsing Pressing Stabbing

What is your <u>overall</u> (total body) level of pain? Please mark your levels on the lines below with an X.

No discomfort Worst pain imaginable

Today 0_____5_____10
At its Worst 0_____5_____10
On Average 0_____5_____10
Pain on Best day 0_____5_____10
Any pain free days? Yes No How many pain free days per month? ___
When were you last completely pain free? _____

Do you clench or grind your teeth? Yes No Don't know
If yes, how do you know? self-aware told by dentist told by others
Do you have a bite splint / night guard?
Please add up how much time your teeth are together or touching in 24 hours? _____
Circle the feeling(s) that let(s) you know when your teeth are touching?
pain tightness fatigue motion touch

List your pain problems.
Prioritize (worst pain first)

1. _____
2. _____
3. _____
4. _____
5. _____

Which pain occurred first?
_____

Does movement initiate or aggravate your pain? Y N ?
_____

Pain
Neck pain? Y N _____ Neck sounds? Y N _____
When did it start? _____ When is it the worst? _____
Any pain from areas below your shoulders? Y N If yes, where? _____
When did it start? _____ When is it the worst? _____
Tooth pain? Y N If yes, where? _____
Does your bite feel different? Y N How?_____
Any altered jaw movement(s)? Y N _____
Any jaw (joint) sounds? Y N _____
Did jaw (joint) sounds begin before your pain started? Y N Unsure
When were you first aware of the sounds? _____
Have there been any changes in the sounds? How? _____
Any jaw pain or stiffness? Y N Morning Evening _____
When is the jaw pain or stiffness worst? Morning Midday Evening _____
Does your problem affect your ability to eat? Y N How? _____
Has you jaw ever locked open? Y N Frequency_____ Trigger _____
Has you jaw ever locked closed? Y N Frequency_____ Trigger _____
How do you get the jaw to unlock? Medications _____ Manipulation _____
Have you ever had to have a dentist or physician unlock your jaw: Y N Who _____
Dizziness or lightheadedness? Y N_____
Ear problems? Y N Fullness Stuffiness Ringing sounds Pain _____
Numbness or tingling? Y N Around mouth Head/Face Arms/Fingers Legs/Toes Other _____
Cold hands/feet? _____
Stomach, intestinal, bowel or bladder problems? Y N _____

Any smell that evokes any bad memories? _____
Do you? bite your nails chew gum protrude tongue hold phone between shoulder and head
Describe any other habits: _____

Headaches

Headaches started ____ years ago
Do you have more than one type of headache? Type:
Describe your headache.
How frequent are the attacks?
Are they increasing in frequency?
How long are the attacks? Without medication: _____ With medication: _____
Are you ever headache free? When:
How severe are the attacks? (Scale of 0-no pain to 10-the worse)
Is there a family history of headaches? Y N
Precipitating event:
Where on your head does the headache pain occur? Circle all appropriate.
Temples, Back of Head, Side of Head, Around the Head, Eye, Ear, Neck, Jaw
How often are the headaches (frequency)?
When do they occur? (morning, evening, etc
How long do they last?
What starts or triggers your headaches?
Are there any activities that worsens the headache?
Are there any things that make the headaches better?
With your headache do you experience? nausea / vomiting / sensitivity to light or sound / dizziness / aura
Does you headaches cause you to miss work, school , or family activities because of your headaches?

Sleep History

In what position do you fall asleep? Lying on your : Back Side Stomach _____
Do you have a regular/consistent sleep schedule? Y N Are you a shift worker? Y N _____
How many hours do you sleep? Average night _____ Good night _____ Bad night _____
Do you have difficulty falling asleep? Y N _____
How long does it take to fall asleep? Average night ____ Good night ____ Bad night ____
Any problems with interruptions/awakenings during sleep? Y N _____
Do you snore? Y N _____
Is your sleep? sound light restless _____
Is your sleep restorative/restful? Y N _____
Have you ever been evaluated for sleep apnea Y N _____

Thank you. The staff will complete the remainder of the form.

INTERVIEW NOTES

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PATIENT NAME: ID NUMBER: DATE: