ADVANCED ORAL AND FACIAL SURGERY OF THE MAIN LINE, PC
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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?

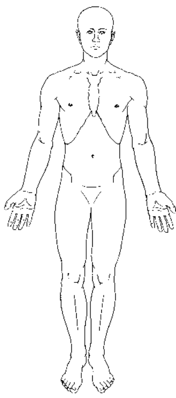
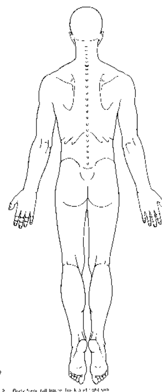
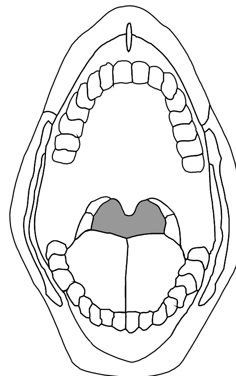
Nicotine Y N How long? _____ cigarettes _____/day cigars_____ pipe _____ snuff _____
Alcohol Y N beer ____ /day wine _____ glasses/day liquor ____ drinks/day
Caffeine Y N cups(cans)day _____ coffee tea soda chocolate
Water Y N glasses/day _____
Juice or milk Y N glasses/day _____
Vitamins Y N multivitamins _____ 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:

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 ?

____

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

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 ____

PATIENT NAME: ID NUMBER: DATE:

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: