Jaw and Facial Pain Questionnaire

Your doctor desires to better understand your problem and requests that you complete this questionnaire. These questions are intended to cover a wide variety of signs and symptoms, meaning that not all questions may seem directly relate to your particular problem. Answer the questions the best you can by printing neatly to fill in the blanks and by checking or circling the most appropriate answer.

Name: ____________________________________      Date: ________________       Age:________
Marital Status: SINGLE     MARRIED DIVORCED WIDOWED
I am RIGHT LEFT handed.  
Sex: MALE FEMALE
I was referred by___________________________________________________________________
My problem started ____________________ DAYS  WEEKS  MONTHS  YEARS ago.  
The pain or problem began as ______________________________________________________
The pain I have now is on the   RIGHT       LEFT      BOTH      side(s).   
If on both sides my problem is worse on the       RIGHT      LEFT      side.    
I would describe the pain as      DULL      SHARP      THROBBING      ELECTRIC 
other__________.
The pain is     CONSTANT      INTERMITTENT .
My problem is worse in the      MORNING      EVENING      AFTER MEALS      NO CERTAIN TIME .
The pain begins in the_____________________ region and then spreads to the _________________ area.

I would rate my pain: on average at  0      1      2      3      4      5      6      7      8      9     10 
and at it's worst at  0      1      2      3      4      5      6      7      8      9     10 

My pain interferes with my ability to
EAT      TALK      SMILE      KISS      SLEEP      FUNCTION

Although variable this pain usually lasts
SECONDS    MINUTES    HOURS    DAYS    WEEKS

My pain IS  IS NOT started by touching specific areas of my face or mouth.

These areas that cause my pain to start are located ________________________________
My pain is now or has been accompanied by the following symptoms:

- ringing in the ears
- dizziness
- slurred speech
- numbness
- seizures
- loss of consciousness
- tingling
- paralysis of arm(s)
- paralysis of leg(s)
- blurred vision
- double vision
- problem walking
- other: ____________________________________________________________________

I am aware of the following:

- difficulty in opening my mouth wide
- a history of my jaw becoming “stuck” or “locked” open
- a history of my jaw becoming “stuck” or “locked” closed
- popping sounds in the right jaw
- popping sounds in the left jaw
- an uncomfortable feeling in the way my teeth come together
- grinding or clenching of my teeth during the day
- grinding or clenching of my teeth during the night
- arthritis or other sore joints
- difficult tooth removal (date: ____________)
- recent general dental procedures (date: ____________)

pain in the:

- right ear
- left ear
- right temple
- left temple
- right neck
- left neck
- right shoulder
- left shoulder
- right jaw during function
- left jaw during function
- teeth
- other ____________________________________________________________________

I HAVE / HAVE NOT had orthodontic (braces) treatment, it was started
___________ (date) by Dr. ________________, in ___________________(city) and was completed
___________ (date) by Dr. ________________, in ___________________(city) .

I HAVE / HAVE NOT had an injury to my HEAD NECK JAW .

Date of First Injury ___________________
Describe Injury
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Date of Second Injury _________________
Describe Injury
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
HEADACHES

I have headaches that occur three or more times per month. Y N

If the answer to the above question is yes, please answer the next nine questions about headaches. If your answer to the above question was no, please skip the next nine questions about headaches.

• I miss work, school, or social activities due to my headaches. Y N
• The intensity of my headache pain is becoming progressively worse. Y N
• My headaches are occurring more frequently. Y N
• I have relative who also suffer from headaches. Y N
• I am taking increased amounts of pain medicine to handle my headaches. Y N
• I have had headache treatment at the emergency room within the last six months Y N
• I have a special feeling or sight or sound that occurs before my headaches. Y N
• My headaches are accompanied by physical symptoms such as dizziness, nausea, numbness, or changes in vision. Y N
• As a women, my headaches are more intense or frequent before or during my menstrual cycle. N/A Y N

PREVIOUS TREATMENT

I HAVE / HAVE NOT had previous treatment for my current problem.

If you have had treatment, please list the treatments with the associated results.

N = not effective  S = somewhat effective  V = very effective

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Provider</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>bite splint #1</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>bite splint #2</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>physical therapy</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>counseling</td>
<td></td>
<td></td>
<td>N S V</td>
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<tr>
<td>chiropractic</td>
<td></td>
<td></td>
<td>N S V</td>
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<tr>
<td>steroid injection(s) to the jaw joint</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>Right</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>TMJ surgery</td>
<td></td>
<td></td>
<td>N S V</td>
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<tr>
<td>Right</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>Left</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>N S V</td>
</tr>
</tbody>
</table>
PREVIOUS MEDICATIONS

The following medications have been used and were EFFECTIVE: ___________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

The following medications have been used and were INEFFECTIVE: _________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

PSYCHO-SOCIAL HISTORY

Which of the following, if any, worsen your pain or problem?

_____ stress       _____ anger           _____ anxiety           _____ frustration

I DO / DO NOT  sleep through the entire night.

I DO / DO NOT  describe my sleep as restful.

I WOULD / WOULD NOT  describe myself as depressed.

If depressed, I HAVE / HAVE NOT had thoughts of suicide.

I HAVE / HAVE NOT had previous psychiatric care for _____________________________

I DO / DO NOT currently smoke or use tobacco products.

I HAVE / HAVE NOT smoked or used tobacco products in the past.

If I have used tobacco products, I have or did use them for _________ years.

I would describe myself as a SOCIAL-DRinker  NON-DRinker  OTHER

My occupation is or was: ____________________________________________________________

FAMILY HISTORY

I HAVE / HAVE NOT had other family members with similar problems. If so, these family members are: ________________________________________________________________
PAST MEDICAL HISTORY

List your medical conditions: _________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

List your past surgeries with dates (in order, first to last):
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

List your current medications (name, strength, frequency):
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

List your medical allergies, including the type of reaction (rash, difficulty breathing, etc.):
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

REVIEW OF SYSTEMS

Do you have now or have you had recently? (Check each that applies)

___ weight gain    ___ weight loss
___ trauma to the head    ___ seizures
___ glaucoma    ___ blindness
___ ear infections    ___ ear stuffiness
___ nose trauma    ___ nasal polyps
___ throat infections    ___ difficulty swallowing
___ sinus allergies    ___ sinus drainage
___ neck stiffness    ___ neck swelling
___ heart murmur    ___ mitral valve prolapse
___ palpitations    ___ rheumatic fever
___ asthma    ___ emphysema
___ ulcers    ___ hepatitis
___ kidney infections    ___ kidney failure
___ thyroid problems    ___ diabetes
___ cancer (list site) _____________________________
___ radiation treatment (list date and site) _____________________________