TMJ/SLEEP APNEA THERAPY AND RESEARCH CENTER

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Facial Pain Examination Form

BACKGROUND INFORMATION

Date: _____

Name: _____

Age: _____

Referring Doctor:_____

1) Briefly, what is bothering you today? _____

_____

_____

Overall, I would rate my pain/discomfort as follows: (make an X on the line at the place that describes the character of your pain/discomfort):

_____

no pain or discomfort — worse pain imaginable

Overall, I would rate my pain as follows: (make an X on the line at the place that describes the impact of the pain/discomfort on your life):

_____

pain does not affect my life — pain has severely impaired my life

PLEASE CIRCLE ANY OF THE DESCRIPTORS THAT APPLY YOUR PAIN:

MY PAIN QUALITY IS: dull-ache, throbbing, sharp, burning, pressure, squeezing, electrical

MY PAIN'S DURATION IS: seconds to minutes, minutes to hours, hours to days, days to weeks, constant

MY PAIN'S FREQUENCY IS: constant, daily, weekly, monthly, less than monthly

MY PAIN IS ASSOCIATED WITH: nausea, tearing, difficulty swallowing, visual disturbances, numbness, loss of balance, loss of muscle strength

MY PAIN IS WORSENED BY: drinking hot and cold things, lowering my head (bending over), eating, opening my mouth wide, lights or brightness, talking, eating, yawning, noise, touching certain areas, nothing; the pains come spontaneously

2) Describe the history of your problem(s) in detail, including:

-When and why your problem(s) began: _____

_____

_____

-List all treatments you have received including how successful the treatments were:

Medicines: _____

Physical Therapy: _____

Splints/Mouthguards: _____
/Nightguards etc.

Injections: _____

TMJ Surgery: _____

Bite Adjustments: _____

Braces/Orthognathic Surgery: _____

Other: _____

-Indicate how your problem(s) have changed over time: improved unchanged worsened

3) Have you suffered any trauma to your head or neck such as car accidents, blows to you face, long dental appointments, tooth extractions or hospital surgeries after which, you experienced facial pain? yes no **If yes, please list and date:**

_____

_____

4) Is your case involved in litigation at this time: yes no

If no, are you planning on litigation in the future: yes no

5) Do you feel that you have a significant amount of stress or anxiety in your life? yes no

Do you feel depressed? yes no

List any significant sources of stress or anxiety in your life and their date of occurrence:

worries/concerns: _____

deaths of close family members: _____

jobs (past and present): _____

interpersonal relationships: _____

finances: _____

relocations: _____

marriage: _____

children: _____

other: _____

6) Regarding your Medical History, please circle any of following problems that you suffer from and give a brief description:

arthritis/ fibromyalgia or other musculoskeletal problems_____

sinusitis _____

oral ulcers _____

stomach problems (such as colitis, ulcers, diarrhea) _____

chronic headaches _____

neuralgias _____

depression _____

allergies or intolerance to medications _____

Please list all medications that you are taking along with the dose and dosing frequency _____

_____

_____

Can you take Anti-inflammatory drugs like Advil, Motrin and Aleve? yes no
-If you cannot please explain _____

SYMPTOMS

1) <u>HEADACHES:</u> (please circle all that apply)

-**Do you experience Headaches?** yes no (if no, skip to #2)

-**The location of the Headaches is:** top sides front back all over

-**The Headaches occur:** constantly daily weekly (how many times per week _____)
monthly (how many times per month _____) less often

-**The timing of the Headaches is**: (if constant, please indicate when are they worse):

mornings afternoons during sleep after meals no predictable pattern

-**The Headaches last for**: seconds minutes hours days constant

-**I would describe the Headache pain as**: dull-ache pressure throbbing squeezing
sharp pain burning electrical

-**The following signs and symptoms can occur with my Headaches**:

nausea sensitivity to bright lights dark spots in your visual field
double vision sensitivity to noise flashing lights in your vision

-How often do these signs and symptoms occur with the Headaches?:

constantly daily weekly monthly less often

-**Medications I take to relieve or improve the headaches are**: (please indicate the success of the meds.)

_____

2) <u>FACIAL or JAW PAIN/DISCOMFORT:</u> (please circle all that apply)

-Do you experience Facial or Jaw pain or discomfort? yes no (if no, skip to #3)

-The Facial (Jaw) pain/discomfort occurs on the: right side left side both sides

-The Facial (Jaw) pain/discomfort occurs: constantly daily weekly (how many times per week _____)

monthly (how many times per month _____) less often

-The Facial (Jaw) pain/discomfort occurs in the: (if constant, indicate when it is worse):

mornings afternoons after meals during sleep no time pattern

-The Facial (Jaw) pain/discomfort lasts for: seconds minutes hours days constant

-The Facial (Jaw) pain/discomfort increases with: eating talking yawning

-The Facial (Jaw) pain/discomfort usually occurs at the same times as the following pains:

headaches ear pain neck/shoulder pain

3) <u>EAR SYMPTOMS:</u> (please circle all that apply)

-Do you experience: Ear pain/discomfort? yes no (if no to all, skip to #4)
Ear stuffiness? yes no
Ringing in your ears? yes no

-In which Ear(s) do you have pain/discomfort, ringing or stuffiness:

	pain/discomfort	ringing	stuffiness
right ear			
left ear			

-The Ear symptoms occur: constantly daily weekly (how many times per week _____)

monthly (how many times per month _____) less often

-The Ear symptoms occur: (if constant, indicate when it is worse)

mornings afternoons during sleep after meals no time pattern

-The Ear symptoms last for: seconds minutes hours days constant

-Do the Ear symptoms occur at the same times as the Facial pain/discomfort? yes no

4) <u>NECK/SHOULDER PAIN/DISCOMFORT:</u> (please circle all that apply)

-Do you experience pain or discomfort in your Neck or Shoulders? yes no (if no, skip to #5)

-The Neck/Shoulder pain (discomfort) occurs in the:

front of the neck back of the neck left shoulder right shoulder

-The Neck/Shoulder pain (discomfort) occurs: constantly daily

weekly (how many times per week _____) monthly (how many times per month _____) less often

-The Neck/Shoulder pain (discomfort) occurs: (if constant, indicate when is it worse)

mornings afternoons during sleep after meals no time pattern

-**The Neck/Shoulder pain lasts for**: seconds minutes hours days constant

-**Does the pain/discomfort increase with moving your Neck?** yes no

-**Do the Neck/Shoulder pain and the Facial pain usually occur together?** yes no

5) JOINT SOUNDS:

-**Do your jaws make noise when you open and/or close your mouth?** yes no (if no, skip to #6)

-**Indicate the jaw and the type of joint noise that you have:**

	clicking/popping sounds	grinding/sandpaper sounds
right joint		
left joint		

-**How long ago did your joint noises begin?** _____

-**Are the joint noises usually associated with pain?** yes no

6) LOCKING:

-**Do your jaws ever get stuck or locked?** yes no (if no, skip to #7)

-**If yes, which type of locking do you experience**:

jaws get stuck open so that you cannot close jaws get stuck closed so that you cannot open I have both types of locking

-**The locking occurs:** daily weekly monthly less frequently

-**The locking seems to occur**: upon wakening with eating with wide opening
at other times (describe) _____

-**When did you first notice the locking?** _____

-**When was the last time you experienced the locking?** _____

7) TRISMUS:

-**Do you feel that your ability to open your mouth is more limited than normal?** yes no

-**If yes, when did you first notice this inability to open as wide as normal**: _____

8) BRUXISM:

-**Do you clench or grind your teeth at night while sleeping?** yes no

-**If yes, how do you know this?** _____

-**Has a sleep partner ever told you that you make noise with your teeth at night?** yes no

-**Do you ever wake in the mornings with your jaws feeling stiff or sore?** yes no

-**If yes, how many mornings a week do you have this stiffness or soreness?**

one or two three or four five to seven

-**Do you ever notice that you clench or grind your teeth during the day time**? yes no

-**If yes, how frequently does this occur?** daily every few days weekly monthly less frequently

9) SLEEP DISRUPTION:

-Do you have difficulty: getting to sleep staying asleep both neither

-If yes, how often does this occur:

every night few times a week every other night few times a month less frequently

-For how long have you experienced this sleep problem? days weeks months years

-Why do you think you experience this these sleeping problems? _____

_____

-Have you been tested for Sleep Apnea? yes no
-If yes, when were you tested? _____ **What was the diagnosis?** none mild moderate severe

-If you have Sleep Apnea, what treatments have you tried? Surgery CPAP Mouthguards Other

-If you have been prescribed CPAP, do you use it? yes no

-Do you snore during sleep? yes no
-If yes, how bad (loud and frequent) is the snoring? _____

-Do you gasp for breath during sleep? yes no

-Are you tired during the daytime? yes no

10) DIETARY RESTRICTIONS:

-Have you had to limit your diet in any way because of this problem? yes no

-If yes, which foods are you avoiding: hard/crunchy foods chewy foods foods that require wide opening
other (please describe) _____

11) PAIN MODIFICATION:

-What have you noticed will increase your pain? weather changes eating talking
opening wide/yawning anxiety/stress clenching/grinding teeth
other (please describe) _____

-What have you noticed will improve your pain? medications (please list) _____
splint/mouthguard
moist heat/ice
other (please describe) _____

12) Do you have aches and pains in other joints (i.e. back, shoulders, hips, knees, hands etc)? yes no

-If yes, have you been diagnosed with a rheumatologic problem? yes no

-Please circle all that apply:
osteoarthritis rheumatoid arthritis fibromyalgia lupus other _____