Craniofacial Pain/ Medical History

Patient's Name: _____ Date: _____/_____/_____

Chief 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 : Number from 0-10. 0 being no pain and 10 being the most severe pain.

	Frequency	**Intensity**
Please number from the most important to the least	0-4	0-10
____ Back Pain	_____	_____
____ Dizziness	_____	_____
____ Ear Congestion	_____	_____
____ Eye Pain	_____	_____
____ Facial Pain	_____	_____
____ Fatigue	_____	_____
____ Headaches	_____	_____
____ Inability to open mouth	_____	_____
____ Jaw Clicking	_____	_____
____ Jaw Joint Noises	_____	_____
____ Jaw Pain	_____	_____
____ Limited Mouth Opening	_____	_____
____ Migraine Headaches	_____	_____
____ Muscle Twitching	_____	_____
____ Neck Pain	_____	_____
____ Pain when chewing	_____	_____
____ Ringing in the ears	_____	_____
____ Shoulder Pain	_____	_____
____ Sinus Congestion	_____	_____
____ Throat Pain	_____	_____
____ Visual Disturbances	_____	_____

Other Complaints:

_____
_____
_____
_____
_____
_____
_____

Craniofacial Pain/ Medical History

Allergens

Antibiotics ☐	Latex ☐	Sedatives ☐
Aspirin ☐	Local Anesthetics ☐	Sleeping Pills ☐
Barbiturates ☐	Metals ☐	Sulfa Drugs ☐
Codeine ☐	Penicillin ☐	Iodine ☐
Plastic ☐		

Other Allergens:

_____
_____
_____
_____
_____
_____
_____

Medications Currently Being 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 ☐	Tranquillizers ☐

Other Medication :

_____
_____
_____
_____
_____
_____
_____

Craniofacial Pain/ Medical History

Medical History

Adenoids Removed ☐
Tonsils Removed ☐
Anemia ☐
Arteriosclerosis ☐
Autoimmune Disorders ☐
Bleeding Easily ☐
Excessive Thirst ☐

Blood Pressure High ☐ Low ☐
Bruising easily ☐
Cancer ☐
Chemotherapy ☐
Chronic Fatigue ☐
Cold hands & feet ☐
Immune system disorder ☐

Injury to:
Face ☐ Mouth ☐
Neck ☐ Teeth ☐

Insomnia ☐
Intestinal Disorders ☐
Jaw Joint Surgery ☐
Kidney Problems ☐
Liver Disease ☐
Meniere's Disease ☐
Menstrual cramps ☐
Multiple Sclerosis ☐
Muscle aches ☐
Muscle shaking ☐
Muscle spasm ☐
Tired muscles ☐

Current pregnancy ☐
Depression ☐
Diabetes ☐
Difficulty concentrating ☐
Dizziness ☐
Emphysema ☐
Epilepsy ☐

Fibromyalgia ☐
Fluid Retention ☐
Frequent cough ☐
Frequent illness ☐
Frequent stressful situations ☐
Muscular dystrophy ☐
Needing extra pillows to help breath at night ☐

Nervous system irritability ☐

Nervousness ☐
Neuralgia ☐
Osteoarthritis ☐
Osteoporosis ☐
Ovarian cysts ☐
Parkinson's Disease ☐
Slow healing scores ☐
Stroke ☐
Tuberculosis ☐
Tumors ☐
Urinary disorders ☐
Wisdom tooth extraction ☐

General anesthesia ☐
Glaucoma ☐
Gout ☐
Hay Fever ☐
Hearing impartment ☐
Heart disorder ☐
Heart murmur ☐
Heart disorder ☐
Heart pacemaker ☐
Heart palpitations ☐
Hemophilia ☐
Hypoglycemia ☐
Poor circulation ☐
Prior orthodontic treatment ☐
Psychiatric care ☐

Radiation treatment ☐

Rheumatic fever ☐
Rheumatoid fever ☐
Scarlet Fever ☐
Shortness of breath ☐
Sinus problems ☐
Skin disorder ☐
Speech difficulty ☐
Swollen, Stiff or painful joints ☐

Tendency for:
Frequent Colds ☐
Ear Infections ☐
Sore Throats ☐

Other Medical/ Dental History:

_____
_____
_____
_____
_____
_____
_____

Craniofacial Pain/ Medical History

Symptoms

Circle the symptoms and indicate severity, frequency and duration. **Do not** forget to mark left, right, or bilateral.

L= Left R=Right B= Bilateral

Head Pain	Location	Severity	Frequency	Duration
L R B	Font of your head (frontal)	Mild, Moderate, Severe	Occ., Frequent, Constant	Sec., Min., Hrs. Days, Wks.
L R B	Entire Head (Generalized)	Mild, Moderate, Severe	Occ., Frequent, Constant	Sec., Min., Hrs. Days, Wks.
L R B	Top of your head (Parietal)	Mild, Moderate, Severe	Occ., Frequent, Constant	Sec., Min., Hrs. Days, Wks.
L R B	Back of your head (Occipital)	Mild, Moderate, Severe	Occ., Frequent, Constant	Sec., Min., Hrs. Days, Wks.
L R B	In your temples (Temporal)	Mild, Moderate, Severe	Occ., Frequent, Constant	Sec., Min., Hrs. Days, Wks.

Jaw Pain

L R B Jaw Pain-Opening

L R B Jaw Pain- While chewing

L R B Jaw Pain- when closing

Jaw Symptoms

Jaw clicking ☐ Jaw locks closed ☐ Jaw locks open ☐

Jaw popping ☐ Teeth clenching ☐ Teeth grinding ☐

Ear Related Conditions

Buzzing in the ears ☐ Ear Congestion ☐ Pain behind ear ☐

Pain or pressure behind ears ☐ 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 ☐ Middle ☐ Upper ☐ Constant feeling of a foreign object in throat ☐ Neck pain ☐

Chronic sore throat ☐ Limited movement of neck ☐ Scoliosis ☐

Difficulty in swallowing ☐ Sciatica ☐ Swollen glands ☐

Shoulder pain ☐ Swelling in the neck ☐ Tingling in the hands/ fingers ☐

Thyroid Enlargement ☐ Tightness in throat ☐ Wryneck ☐

Craniofacial Pain/ Medical History

Pain History

Again what are your chief complaints (main concerns) listing the most important first

1) _____ Date _____/_____/_____

2) _____ Date _____/_____/_____

3) _____ Date _____/_____/_____

4) _____ Date _____/_____/_____

5) _____ Date _____/_____/_____

6) _____ Date _____/_____/_____

Are you in pain now? ☐ Yes ☐ No

On this pain scale of 1-10 (10 being the most severe) circle the number 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	Bright	Stimulating	Burning	Raw
B.	Shocking	Piercing		Electric	Lancinating
C.	Dull	Arching	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/ 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 the day goes on
F.	**Pattern of Pain:**	Worse at waking	Worse at Night	Increases as the day goes on	

Number of days per months with: headaches _____ neck ache _____ tooth pain _____

How many types of headaches do you have? _____

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

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

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

Craniofacial Pain/ Medical History

Medication taken for this condition:

1) _____ Results: _____

2) _____ Results: _____

3) _____ Results: _____

Relieved by: Please circle

Antihistamines	Muscle Relaxers
Antidepressants	Codeine/ Narcotics
Antianxiety	Cardiac/ Blood Pressure
Aspirin/ Tylenol	Migraine Meds

Are you willing to give you 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 your life? ☐ Yes ☐ No

How? _____

_____

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

- ☐ A motorcycle 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: _____

_____

_____

Craniofacial Pain/ Medical History

History of Symptoms

The patient states the condition first occurred when:

_____

_____

_____

_____

_____

_____

Family History

Have any members of your family have:

Headaches ☐ High Blood Pressure ☐

Heart Disease ☐ Diabetes ☐

Social History:

Occupation: _____

Do you have children? Yes ◯ No ◯ How many? _____ Age? _____

Are you currently living under stress? Yes ◯ No ◯

Recent change in lifestyle? Yes ◯ No ◯

Do you exercise regularly? Yes ◯ No ◯

Do you smoke? Yes ◯ No ◯ Amount? _____

Do you chew tobacco? Yes ◯ No ◯

Number of caffeine drinks per day? _____

Alcohol consumption? None ◯ Occasional ◯ Social Drinker ◯ Daily ◯

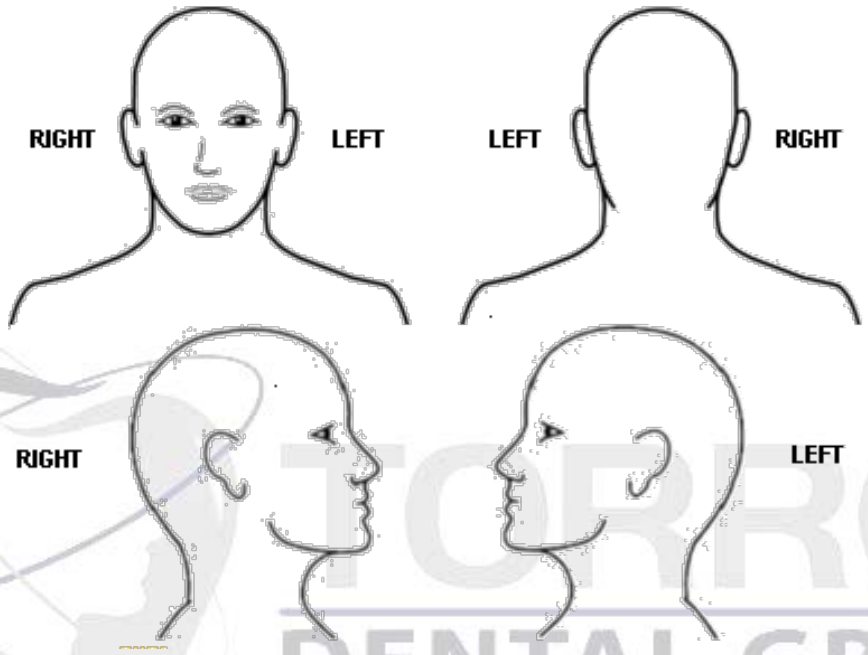
Craniofacial Pain/ Medical History

Check the intensity of your pain inside of the picture.

Mild: MI

Moderate: M

Severe: S



Dr. Maria Claudia Torres

(718) 899- 3840
78-11 35th Avenue, Suite 1E
Jackson Heights, New York 11372

www.torresdentalgroup.com

PRINT SEND