RIGALI ORTHODONTIX

CHANGING LIVES ONE SMILE AT A TIME

Orofacial pain and temporomandibular joint disorder patient history and questionnaire

Date: ____/____/____

Name: _____ Sex: M☐ F ☐ Date of Birth: ____/____/____ Age: ___

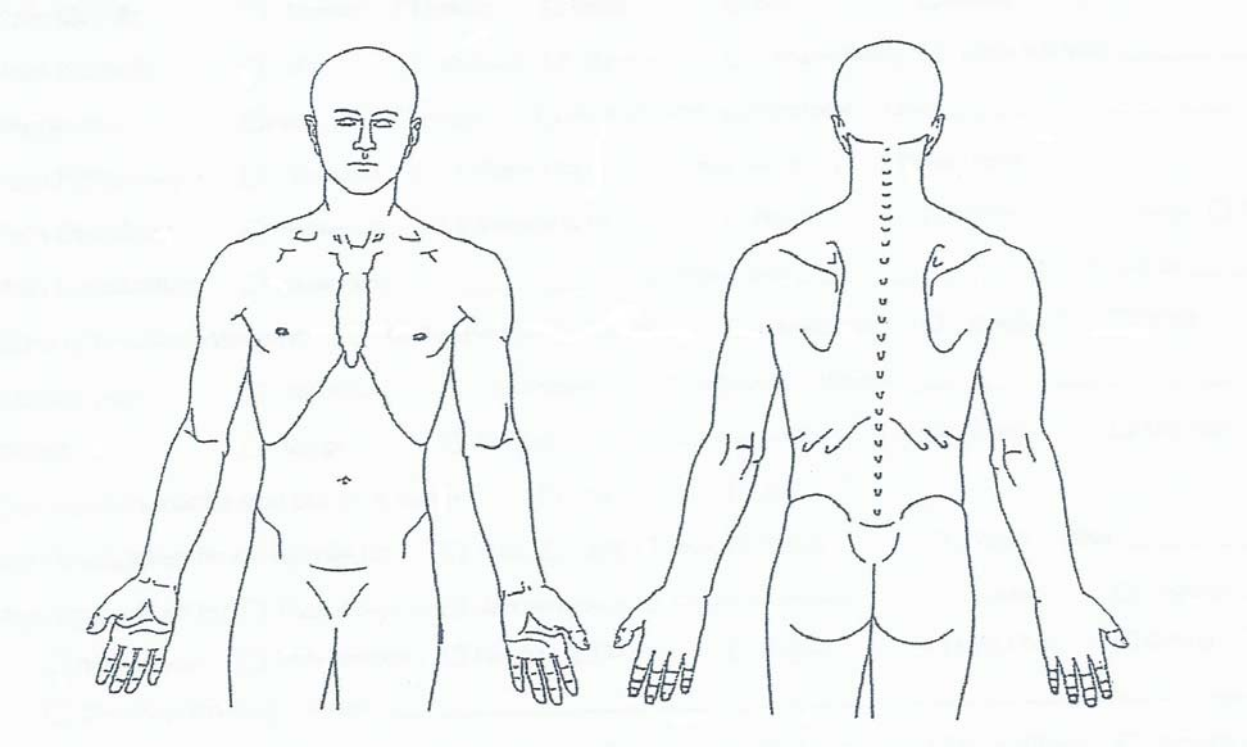
Occupation: _____ Physician: _____ Dentist: _____

Referred by: _____ Chief Complaint/Concern: _____

_____

Location

Please draw where your pain occurs. If you have multiple sites of pain, please number them from one to ten with the most painful site being #1.



Has the location or type of pain changed since its initial occurrence? ☐No ☐ Yes Explain:

_____

_____

_____

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GENERAL PAIN / PROBLEM ASSESSMENT

Do you have?

Facial Pain	☐ No	☐ Yes, Rt.	☐ Yes, Lt.	☐ Past	Dental pain	☐No	☐Yes, Rt.	☐ Yes, Lt.	☐ Past
Jaw Joint Pain	☐ No	☐ Yes, Rt.	☐ Yes, Lt.	☐Past	Jaw muscle pain	☐No	☐ Yes, Rt.	☐ Yes, Lt.	☐ Past
Headaches	☐ No	☐ Yes, Rt.	☐ Yes, Lt.	☐Past	Neck Pain	☐ No	☐ Yes, Rt.	☐ Yes, Lt.	☐ Past
Shoulder Pain	☐ No	☐ Yes, Rt.	☐Yes, Lt.	☐ Past	Earaches	☐ No	☐ Yes, Rt.	☐ Yes, Lt.	☐ Past
Ringing in the ears	☐ No	☐ Yes, Rt.	☐Yes, Lt.	☐Past	Dizziness	☐ No	☐ Yes		☐ Past
Change in hearing	☐ No	☐ Yes, Rt.	☐Yes, Lt.	☐ Past	Change in bite	☐No	☐Yes		☐ Past

HEAD and NECK PAIN / SYMPTOMS

1. Date of Onset and side: (R) _____ (L) _____
2. Area(s) of onset: _____
3. Circumstances surrounding onset, if known: _____
4. Pain Type: ☐ Superficial ☐ Piercing ☐ Throbbing ☐ Pulsing ☐Severe ☐ Spontaneous ☐ Fit-like
5. Pain Quality: ☐ Burning ☐ Aching ☐ Bright ☐ Dull ☐ Itching
6. Pain Intensity: ☐ Mild ☐ Moderate ☐Severe ☐ Incapacitating ☐ Limits activities: _____
7. Numbness: ☐ Face ☐ Head ☐Neck/Shoulder ☐ Arm/Hand Other: _____
8. Pain Frequency:☐ Constant ( ) Times/Day ( ) Times/Week ( ) Times/Month
9. Pain Duration: ☐ Momentary ☐ Seconds to Minutes ☐ Hours ☐All Day ☐ Days ☐Constant
10. Pain Localization:☐ Localized to _____ ☐ Diffuse over _____ ☐ Radiates to _____
11. Time of greatest intensity: ☐ On Awakening ☐ Morning ☐ Afternoon ☐ Evening ☐ Night
12. Current Pain: ☐ Increased ☐ Decreased ☐Unchanged When? _____
13. *Onset:* ☐ Abrupt ☐ Gradual *Disappearance:* ☐ Abrupt ☐ Gradual
14. Can the pain awake you out of sleep? ☐ Yes ☐ No
15. Pain is triggered by sensitivity to: ☐ Food ☐ Light ☐ Sound ☐ Odors ☐ Touch Other: _____
16. Pain aggravated by: ☐ Face movement ☐ Jaw movement ☐ Tongue movement ☐Chewing ☐ Talking ☐ Swallowing
    ☐ Head position ☐Body position ☐ Activity ☐ Tension ☐ Fatigue ☐Heat/Sun ☐Driving
    ☐Foods ☐ Clenching/Grinding Other: _____
17. Pain accompanied by: ☐ Nausea ☐ Eye spots ☐ Dizziness ☐ Sweating ☐ Neck stiffness ☐ Stomach cramps
18. Pain is relieved by: _____
19. Longest pain-free period? _____
20. Pain in specific teeth? _____
21. Sore throat or difficulty swallowing? ☐ Yes ☐ No

EAR / TMJ / DENTAL SYMPTOMS

1. Do you have pain in or about the ear(s)? ☐ No ☐ Yes, right ☐ Yes, left
2. Do you have dizziness? ☐ Spinning ☐ Lightheaded ☐ Fainting ☐ Meniere's disease
3. Do you have ear noise? ☐ Ringing: ☐ R ☐ L ☐ Popping: ☐ R ☐ L ☐ Whooshing: ☐ R ☐ L ☐ Clicking: ☐ R ☐ L
4. Have you noticed a decrease in hearing acuity? ☐ No ☐ Yes ☐ Stuffiness ☐ Excessive ear wax ☐ R ☐ L
5. Do you have a history of ear infections or operations? ☐ No ☐ Yes, right ☐ Yes, left
6. Do you have pains in your ☐ Tongue ☐ Throat ☐ Right cheek ☐ Left cheek
7. Does your jaw hurt? ☐ No ☐ Right ☐ Left
8. Do you have jaw or facial muscle fatigue? ☐ No ☐ Yes, when: _____
9. Have you noticed any facial swelling? ☐ No ☐ Yes, Right ☐ Yes, Left
10. Does your jaw make a noise?

    Right side ☐ No ☐ Clicking ☐ Popping ☐ Grinding ☐ Other _____

    When? _____ How long? _____

    Left side ☐ No ☐ Clicking ☐ Popping ☐ Grinding ☐ Other _____

    When? _____ How long? _____
11. Has your jaw ever locked?

    Right side ☐ No ☐ Yes ☐ Current ☐ In the past

    ☐ Open When? _____ How frequent? _____

    ☐ Closed When? _____ How frequent? _____

    Left side ☐ No ☐ Yes ☐ Current ☐ In the past

    ☐ Open When? _____ How frequent? _____

    ☐ Closed When? _____ How frequent? _____
12. Do you grind or clench your teeth? ☐ No ☐ Yes ☐ Daytime ☐ Night
13. Do you have sore or sensitive teeth? ☐ No ☐ Yes ☐ Hot ☐ Cold ☐ Sweets ☐ Chewing
14. Do you lose or break filings? ☐ No ☐ Yes Do you have cracked or broken teeth? ☐ No ☐ Yes
15. Do you have loose or mobile teeth? ☐ No ☐ Yes Do your gums bleed? ☐ No ☐ Yes
16. Do your gums feel tender or swollen? ☐ No ☐ Yes Have you ever had periodontal treatment? ☐ No ☐ Yes

    When? _____ Dr. _____
17. Do you have noticeable wear on your teeth? ☐ No ☐ Yes Food traps? ☐ No ☐ Yes
18. Are you missing any teeth? ☐ No ☐ Yes Have they been replaced? ☐ No ☐ Yes

    if so, how? ☐ Fixed bridge ☐ Removable partial ☐ Full denture ☐ Dental implant
19. Are you comfortable with the replacement? ☐ Yes ☐ No Comment? _____
20. Have you noticed a change in your bite? ☐ No ☐ Yes When? _____

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GENERAL WELLNESS ASSESSMENT

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Remarried

Do you have difficulty getting to sleep? ☐No ☐ Yes Do you sleep well? ☐ Yes ☐No ☐ Sometimes

Is your sleep interrupted? ☐ No ☐Yes Do you consider yourself to be under a lot of stress? ☐ No ☐Yes

Distress or Mental anguish caused by: ☐ Spouse ☐Children ☐ Mother ☐Father ☐Friends ☐Work

☐ Economics ☐ Other: _____

How would you rate your irritability level? ☐Mild ☐ Moderate ☐ Severe _____

How would you rate your anxiety level? ☐ Low ☐ Moderate ☐High How is it experienced? _____

Ave you had a problem with? ☐None ☐ Concentrating ☐ Memory ☐ Panic attacks ☐ Crying spells

☐ Weight loss/gain ☐ Libido ☐ Anger outbursts ☐ Impulsiveness ☐ Appetite

Have you had a problem with? ☐ None ☐ Nervous Stomach ☐ Ulcers ☐ Skin disease ☐ Allergies

Occupation: _____ Hours worked/week: _____ Years employed at present job: _____

Do you like your job? ☐ Yes ☐ No Explain: _____

Is there anything about your job that causes you excessive stress or anxiety? _____

What job would you like to do? _____ Have you had a change in employment? ☐ No ☐ Yes

Do you exercise? ☐ Daily ☐ ( ) x's per week ☐ Rarely ☐ Never

What do you do for exercise? _____

Do you have or have you ever had arthritis? ☐No ☐ Yes ☐ Past Where? _____

Does your family have a history of arthritis? ☐ No ☐ Yes ☐ Past Where? _____

Does your pain keep you from doing anything? ☐ No ☐ Yes What? _____

Do you recall any injury to your jaw, head or neck? ☐ No ☐Yes Date(s): _____

Describe: _____

_____

Do you take any medications for pain? ☐ No ☐ Yes If yes, what? _____

Do you take any medications for relaxation or sleep? ☐No ☐ Yes If yes, what? _____

Have you had any treatments for your problem? ☐No ☐ Yes If yes, what? _____

Bite splint _____ Occlusal adjustment _____

Medication _____ Orthodontics _____

Physical Therapy _____ Surgery_____

Chiropractic _____ Medication _____

Counseling _____ Other _____

Please add anything else that you feel is important: _____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____

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