Member American Association of Orthodontists

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Diplomate, American Board of Orofacial Pain

Practice Limited to Orthodontics & TMD

Health History Part II

Patient's Name: Date: Age: Sex:

Date of Birth: Home Phone: Occupation:

Chief Complaint:

Duration of the problem:

Problem most severe: ☐Morning ☐Afternoon ☐Evening ☐Sleeping ☐Eating ☐No pattern

SYMPTOMS					Left	Right
Face Pain	☐Forehead	☐Cheek	☐Nose	☐Around Eyes	☐	☐
Head Pain	☐Front	☐Back	☐Side	☐Top	☐	☐
Ear	☐Pain	☐Stuffy	☐Ringing	☐Loss of hearing	☐	☐
Eye	☐Pain	☐Redness	☐Pressure	☐Loss of Focus	☐	☐
Arm/Fingers	☐Pain	☐Tingling	☐Numbness	☐Weakness	☐	☐
Throat	☐Pain	☐Tightness	☐Dryness	☐Difficult to swallow	☐	☐
Jaw Joint	☐Pain	☐Clicking	☐Grinding	☐Locking open/closed	☐	☐
Upper Back	☐Pain	☐Stiffness	☐Spasm	☐Noise on movement	☐	☐
Lower Back	☐Pain	☐Stiffness	☐Spasm	☐Noise on movement	☐	☐

Dental Problem:
Bite Problem:
Other:

Pain Type: ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Dull ☐ Deep ☐ Prickling

☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe ☐ Agony

☐Location: ☐ Localized ☐ Generalized ☐ Radiating ☐ Migrating

Duration: ☐ Intermittent ☐ Recurrent ☐ Continuous

What is your worst symptom?

What Makes it feel better?

What Makes it Feel Worse?

Family History of TMJ disorders and Pain:

Habit History: ☐ Gum Chewing ☐ Nail Biting ☐ Musical Instrument ☐ Other:

☐ Clenching ☐Grinding

Daily Activities

Type of Exercise: Frequency:

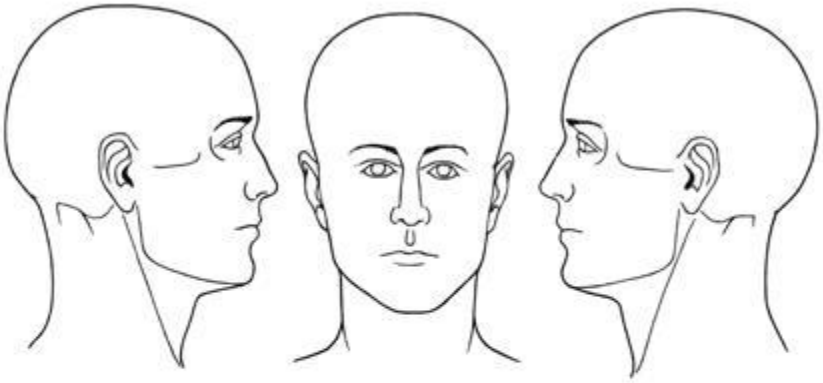
Home/Work Daily Habits:

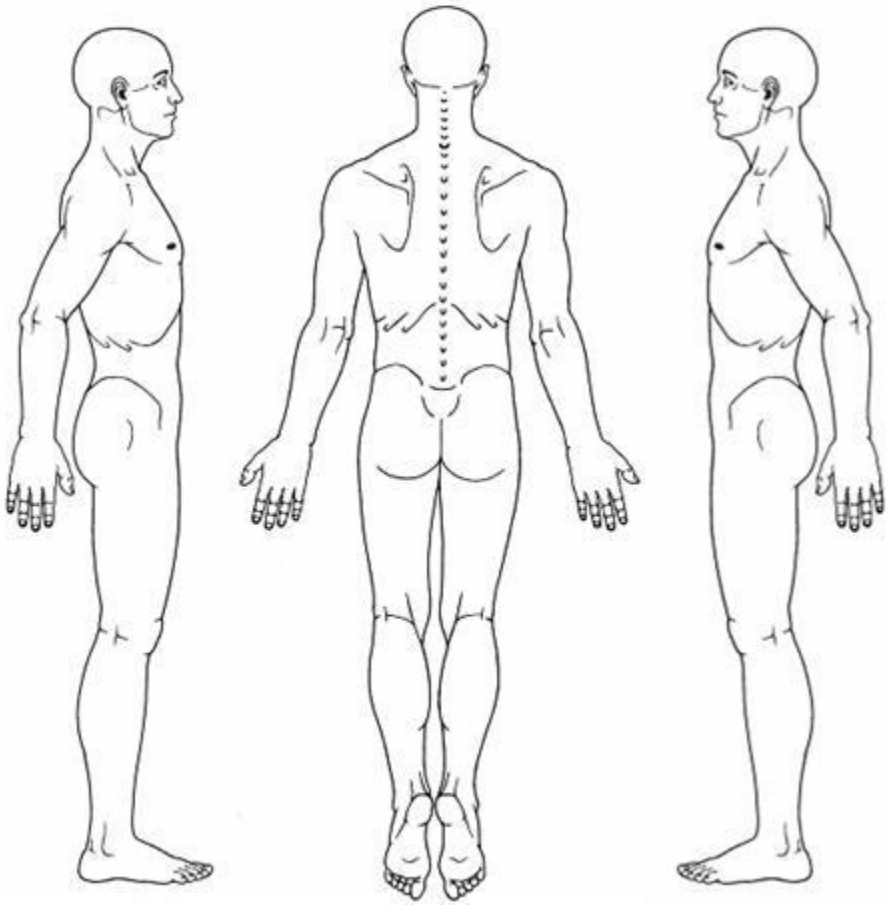
Usual Posture and position at work:

Please indicate pain areas, type and level of pain / discomfort on the diagram below as felt on your worst day.

Type of Pain: B: *Burning* T: *Throbbing* S: *Sharp* D: *Dull*

0 - 1	**2 - 3**	**4 - 5**	**6 - 7**	**8 - 9**	**10**
No Pain	*Mild Pain*	*Moderate Pain*	*Severe Pain*	*Agony*	*Unbearable*





Medication history

Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
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Referral and Doctor Information

Who referred you to this office?	
Do you want a copy of your findings sent to the above? ☐ Yes ☐ No	
Please list previous and present health care providers. Fill all fields and indicate if you want a copy of your findings sent to that provider.	
☐ Send a report ☐ Do not send a report	Name: Specialty: Address: Phone: Diagnosis and Treatment:
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Trauma History: In an effort to provide you with the best care possible, it is very important that we have as complete and as detailed a history of injuries you have sustained and treatments received. In addition there are certain lifestyle factors which interfere with treatment. Therefore we will be interested in aspects of your life which you may, at first glance, this unrelated to the problems which prompted your coming to the Gelb Center.

Have you been involved in accidents in the past which you head was snapped as in whiplash auto accidents? _____. If so please list every accident of this type.

Have you received a blow to the face or jaw? _____. If so please list every accident or incident of this type.

Have you been involved in any other types of accident, fall, injury requiring surgery? _____
If so please list every incident.

Please list the treatment you have received for accidents or incidents listed.

Please list previous treatments for the condition which prompted your coming to this center.

Are you presently in litigation related to head, neck, back and/or symptoms ☐**Yes** ☐**No**

If yes, please have copies of any medical records related to this injury forwarded to our center.

Nature of litigation:

Are you currently not working due to disability? ☐**Yes** ☐**No**

Partial disability _____ Total disability _____

If yes, what is the nature of your disability?

Date you stopped working
When has your physicians indicated that you can't return to work?

CHRONOLOGICAL HISTORY

Please give a <u>detailed</u> chronological history of the condition for which you have come to be examined. ***It is pertinent to your treatment that this portion is filled out with specific information as to the onset of your illness*** **to present time.**

FOR PATIENT'S USE	DOCTOR'S USE

FOR PATIENT'S USE	DOCTOR'S USE

FOR PATIENT'S USE	DOCTOR'S USE