

3. Do you have pain in your face or jaw? Yes No

Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10

no pain extreme pain

4. Describe the pain:

Dull Aching Burning
 Throbbing Pressure Pulsating
 Stabbing Sharp Other

5. Does the pain radiate, travel, or move from the area of initial pain? Yes No

Pain moves up the side of the head
 Pain moves around to the back of the head
 Pain moves down the neck

Other _____

6. How long have you had this pain?

Number of: years month weeks

7. When do you have pain?

Constantly
 Frequently but not predictably
 Frequently and predictably
 Occasionally
 No real pattern

8. How long does the pain last?

Less than 1 minute
 1-10 minutes 6-12 hours
 Less than 1 hour 13-24 hours
 1-5 hours Constant

9. Do you have numbness or unusual feelings or sensations in your face or jaw?

yes no

10. Do any of the following cause or aggravate the pain?

Chewing Yawning
 Opening mouth wide Laughing

Talking Singing
 Playing a musical instrument
Other _____

11. What relieves the pain?

Massage of the area Sleep
 Warm soaks or compresses Time
 Holding jaw in certain Relaxation
 Pain medication Nothing helps
 Moving or manipulating jaw Nothing helps
Other _____

12. Do you have problems with your ears?

Yes No Which side? right left
If yes, which of the following?
 pain buzzing ringing stuffiness
Other _____

13. Are you bothered by dizziness or dizzy spells?

Yes No

14. Do you have pain in the cheek? Yes No

Which side? right left both sides

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15. Do you have pain in the temple or above the ear?

Yes No

Which side? right left both sides

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no pain extreme pain

16. Do you have pain in your neck? Yes No

Which side? right left front back

Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10
no pain extreme pain

17. Do you have pain in you back? ____ Yes ____ No
Which side? ____ right ____ left ____ both ____ middle

Using the rating scale indicate the severity of the pain you are experiencing by circling the appropriate area:

0 1 2 3 4 5 6 7 8 9 10
no pain extreme pain

18. Do you have pain, numbness or tingling in your arms, hands, or fingers?
____ Yes ____ No

Which side? ____ right ____ left ____ both

19. Have you ever been in an accident or received a “blow” or injury to any part of you face, head, neck or back?
____ Yes ____ No

20. Are you aware of your jaw making sounds? ____ Yes ____ No
Which side? ____ right ____ left ____ both sides

If yes, describe the nature of the sound:

____ clicking ____ popping
____ grating ____ cracking

Other _____

If yes, when do you notice the sound?

____ Early opening ____ Moving jaw to the side
____ Middle opening ____ Chewing
____ Wide opening ____ While closing

If yes, is the sound always present? ____ Yes ____ No

If yes, is there pain associated with the sound?

____ Yes ____ No ____ Sometimes

21. Has your jaw ever locked open? Yes No
 right side left side both sides

Date of first occurrence _____

If so, can you replace the jaw to normal position yourself? Yes No

22. Has your jaw ever locked closed? Yes No
 right side left side both sides

23. How many times has your jaw locked open or closed during the past year?

24. Is there pain when your jaw locks open or closed? Yes No

25. Have you noticed any decrease in how far you can open your mouth?
 Yes No

26. When you open your mouth, does something in your jaw joint feel like it is in the way? Yes No
Which side? right left both sides

27. Do you need to move your jaw from side to side or forward to enable you to open or close your mouth? Yes No
Which side? right left both sides

28. What foods do you avoid eating because of this problem?
 Hard foods Chewy foods None
Other _____

29. On which side of your mouth do you do most of your chewing?
 right left can't tell

30. Do you have pain when you chew? Yes No
Which side? right left both sides

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31. Have you ever had braces on your teeth? Yes No
If yes, when? _____

32. Do you chew gum? Yes No If yes, how much?
 0-25% of waking hours 50-75% of waking hours
 25-50% of waking hours 75-100% of waking hours
33. Do you have any other oral habits or practices that may aggravate or cause pain?
 Yes No If yes, what? _____
34. Do you clench your teeth? Yes No
 When? under tension while sleeping
35. Do you grind your teeth? Yes No
36. Do you feel that clenching or grinding your teeth causes or contributes to your pain?
 Yes No Sometimes
37. Do you feel that you are under stress much of the time?
 Yes No Occasionally
38. Does increased stress seem to make the pain problem worse?
 Yes No Occasionally
39. Do you sleep well? Yes No
 The pain problem is affecting my sleep.
40. Do you awaken frequently during the night? Yes No
41. Do you go to bed more tired than your daily activities justify? Yes No
42. Do you feel rested when you get up in the morning? Yes No
43. Are you "stiff" or sore when you wake up in the morning? Yes No
44. Do you wake up with a headache? Yes No
45. Do you have headaches later in the day? Yes No
46. Do you have headaches as often as once per week? Yes No
 If yes, how many per week? _____
47. Is there any nausea or vomiting associated with your headaches? Yes No
48. Are there vision changes associated with your headaches?
 Yes No If yes, what kind? _____

49. Do you take any medication for the headache pain?
____ Yes ____ No If yes, what? _____

50. What relieves the headache?
____ Pain medication ____ Rest
____ Sleep ____ Exercise
Other _____

51. Do you tire of fatigue easily? ____ Yes ____ No

52. For each of the beverages listed below, write in the average number you drink each day:

Natural coffee ____ cups/day
Decaffeinated coffee ____ cups/day
Tea ____ cups/day
Carbonated soft drinks ____ cans or bottles/day

53. Do you feel that you usually eat a healthful, balanced diet: ____ Yes ____ No

54. Do you get any type of regular exercise? ____ Yes ____ No
If yes, what kind? _____

55. Do you enjoy your job? ____ Yes ____ No

56. Are you presently, or have you ever been under the care of a psychiatrist or a psychologist? ____ Yes ____ No If yes, when? _____

57. Have you seen a physician, dentist, physical therapist, osteopath, chiropractor, or other health care person for your pain? ____ Yes ____ No

List the names of the persons who have previously treated your facial pain and the kind of treatment you received:

GENERAL MEDICAL HISTORY

1. Have you been to see a physician within the past 2 years? ____ Yes ____ No
If yes, for what problem? _____

2. Please give the name and address of your regular physician:

3. Circle any of the following which you have had or have at the present:

Heart Failure	Chronic Cough	Hepatitis
Heart Disease or Heart Attack	Tuberculosis (TB)	Liver Disease
Angina Pectoris	Asthma	Yellow Jaundice
High Blood Pressure	Hay Fever	Blood Transfusion
Heart Murmur	Sinus Trouble	Drug Addiction
Rheumatic Fever	Allergies or Hives	Hemophilia
Congnital Heart Lesions	Diabetes	Venereal Disease (Syphilis, Gonorrhea, Chlamydia)
Artificial Hear Valves	Thyroid Disease	Genital Herpes
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores or Fever Blisters
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Epilepsy or Seizures
Artificial Joint	Arthritis	Fainting or Dizzy Spells
Anemia	Cortisone Medicine	Depression
Stroke	Glaucoma	Nervousness or anxiety
Kidney Trouble	AIDS	Psychiatric Treatment

Stomach Ulcers

White or Blue
Patches in Mouth

Sickle Cell Disease

Colitis

Emphysema

Persistent
Diarrhea

Enlarged Glands or
Lymph Nodes

4. Have you been a patient in the hospital in the past 2 years? Yes No
If yes, for what problem? _____
5. Have you ever had any operations or surgery? Yes No
If yes, what was the problem? _____
6. Have you ever had any excessive bleeding requiring special treatment?
 Yes No
7. Are you taking any medicines, drugs, or pills or any kind? Yes No
If yes, what kind? _____
8. Do you have any allergies to drugs or medicines? Yes No
If yes, to what and how do you react? _____

9. Have you ever had an unusual reaction to a dental anesthetic? Yes No
10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Yes No
11. Do your ankles swell during the day? Yes No
12. Do you sleep on more than two pillows? Yes No
13. Do you ever wake up from sleep short of breath? Yes No
14. Have you unintentionally lost or gained more than 10 pounds in the past year?
 Yes No
15. Are you on a special diet? Yes No
16. Has your medical doctor ever said you had a cancer or tumor? Yes No
17. Do you have any disease, condition, or problem not listed? Yes No

18. WOMEN: Are you pregnant now? Yes No
Are you practicing birth control? Yes No
Do you anticipate becoming pregnant? Yes No