CAROLINAS CENTER FOR
Oral & Facial Surgery

Pain/TMJ Medical History

PATIENT NAME: _____ **AGE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

1. Are you allergic to any medicines, latex, eggs, or soybeans? *List any medication and reaction to medication.* _____ ◯ YES ◯ NO
2. Do you take any medications (prescription or over-the-counter), supplements, or herbal therapy regularly now? *List name, strength, & frequency of current medications:* _____ ◯ YES ◯ NO
3. Have you been a patient in a hospital during the past 2 years? ◯ YES ◯ NO
4. Are you now or have you been under the care of a physician during the past 2 years? ◯ YES ◯ NO
5. Have you ever had any type of surgery? *Please list:* _____ ◯ YES ◯ NO
6. Have you had excessive bleeding requiring Special treatment? ◯ YES ◯ NO
7. Are you pregnant? ◯ YES ◯ NO
8. Have you ever had an artificial joint placed? ◯ YES ◯ NO
9. Do you get regular exercise? ◯ YES ◯ NO
10. Do you use or have you used tobacco products? ◯ YES ◯ NO
11. Do you use recreational drugs? ◯ YES ◯ NO
12. Do you drink alcohol? (Number of drinks per week _____) ◯ YES ◯ NO

CHECK YES OR NO AS TO WHETHER YOU NOW OR IN THE PAST HAVE HAD PROBLEMS WITH AND/OR TREATMENT FOR:

◯ YES ◯ NO Heart Trouble
◯ YES ◯ NO Asthma
◯ YES ◯ NO Arthritis
◯ YES ◯ NO Breathing Disorder
◯ YES ◯ NO Congenital Heart Defects
◯ YES ◯ NO Stroke
◯ YES ◯ NO Heart Murmur
◯ YES ◯ NO Diabetes
◯ YES ◯ NO Epilepsy
◯ YES ◯ NO High Blood Pressure
◯ YES ◯ NO Low Blood Pressure
◯ YES ◯ NO Tuberculosis
◯ YES ◯ NO Psychiatric Treatment
◯ YES ◯ NO Anemia
◯ YES ◯ NO Hepatitis
◯ YES ◯ NO Sinus Trouble
◯ YES ◯ NO Rheumatic Fever
◯ YES ◯ NO Jaundice
◯ YES ◯ NO Kidney Disease
◯ YES ◯ NO Alcohol Use
◯ YES ◯ NO HIV
◯ YES ◯ NO Immune System Disorder
◯ YES ◯ NO TMJ Disorder
◯ YES ◯ NO Coronary Disease
◯ YES ◯ NO Anxiety / Depression
◯ YES ◯ NO Difficulty Sleeping/ Insomnia
◯ YES ◯ NO Fibromyalgia
◯ YES ◯ NO Excessive Daytime Sleepiness
◯ YES ◯ NO Glaucoma
◯ YES ◯ NO Gout
◯ YES ◯ NO Hemophilia
◯ YES ◯ NO Cancer
◯ YES ◯ NO Chemo / Radiation
◯ YES ◯ NO Chronic Fatigue
◯ YES ◯ NO Chronic Pain
◯ YES ◯ NO Nasal Allergies
◯ YES ◯ NO Meniere's Disease
◯ YES ◯ NO Muscular Dystrophy
◯ YES ◯ NO MS
◯ YES ◯ NO Osteoporosis
◯ YES ◯ NO Parkinson's
◯ YES ◯ NO Sleep Apnea
◯ YES ◯ NO Orthodontic Treatment
◯ YES ◯ NO Rheumatoid Arthritis
◯ YES ◯ NO Thyroid Disorder
◯ YES ◯ NO Recurrent Ear Infections
◯ YES ◯ NO Urinary Disorders
◯ YES ◯ NO Tumors

OTHER SYMPTOMS

- YES NO Teeth Grinding
- YES NO Teeth Clenching
- YES NO Dry Mouth
- YES NO Broken Teeth
- YES NO Ear Pain
- YES NO Ear Congestion
- YES NO Blurred Vision
- YES NO Eye Pain
- YES NO Chronic Sore Throat
- YES NO Feeling of Foreign Object in Throat
- YES NO Swelling in Neck
- YES NO Shoulder Pain
- YES NO Burning Tongue
- YES NO Snoring
- YES NO Tightness in Throat
- YES NO Joint Stiffness
- YES NO Headaches
- YES NO Skin Lesions
- YES NO Muscle Weakness or Paralysis
- YES NO Nail Malformations
- YES NO Fibromyalgia
- YES NO Numbness / Tingling in Hands or Fingers

REVIEW OF SYMPTOMS IN THE LAST 2 WEEKS

- YES NO Appetite Changes
- YES NO Marked Weight Changes
- YES NO Night Sweating
- YES NO Recent Trauma / Infection
- YES NO Tire Easily
- YES NO Ringing in Ears
- YES NO Sinus Infection
- YES NO Sore Throat / Hoarseness
- YES NO Swallowing Difficulty
- YES NO Ulcers or Lumps in Mouth
- YES NO Sore Gums or Tongue
- YES NO Neck Pain
- YES NO Neck Stiffness
- YES NO Persistent Cough
- YES NO Wheezing
- YES NO Shortness of Breath
- YES NO Swelling of Ankles
- YES NO Bruising Easily
- YES NO Arrhythmia
- YES NO Heart Burn
- YES NO Back Pain
- YES NO Muscle Cramps / Pain
- YES NO Dizziness
- YES NO Increased Thirst
- YES NO Heat Intolerance
- YES NO Cold Intolerance
- YES NO Increased Urination

1. Do you have any medical or dental problems? YES NO Explain: _____
2. Over the past two weeks, how often have you felt the following problems?

   Not at All = 0, Several Days =1, More than Half the Days = 2, Nearly Every Day = 3

   Feeling nervous, anxious, or on edge _____ Not being able to stop or control worrying _____

   Feeling down, depressed, or hopeless _____ Little pleasure or interest in doing things _____
3. Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in each situation?

   0 = No Chance of Dozing, 1 = Slight Chance, 2 = Moderate Chance, 3 = High Chance

   Sitting & reading _____ Watching TV _____ Sitting inactive in public (ie theater) _____

   Passenger in a car (1 hr.+) _____ Lying down in the afternoon _____ Sitting and talking to someone _____

   Sitting quietly after lunch _____ In a car, while stopped for a few minutes in traffic _____

WITH HEADACHES, DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- YES NO Aura
- YES NO Sensitivity to Noise
- YES NO Sensitivity to Light
- YES NO Fatigue
- YES NO Dizziness
- YES NO Throbbing
- YES NO Agitation
- YES NO Burning
- YES NO Double Vision
- YES NO Vomiting
- YES NO Restlessness / Anxiety
- YES NO Redness
- YES NO Eyes Drooping
- YES NO Swelling
- YES NO Congestion/ Runny Nose
- YES NO Nausea

Which side are the headaches worse? ◯ **LEFT** ◯ **RIGHT** Where does the headache spread? _____

How many headache days per month? _____

CHIEF COMPLAINT

What information is important regarding the pain or condition that brings you here? _____

_____

_____

_____

_____

Frequency and Duration of chief complaint pain? _____

_____

Describe the pain (Ex: Burning, Aching, Throbbing, Sore, Pressure, Sharp, Dull, Shooting) _____

Is there anything that makes your pain/discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

1. Rate your level of pain from 0 – 10, with 0 = None At All and 10 = Worst Possible

	TMJ	FACE	HEADACHE
PAIN AT THIS MOMENT			
PAIN AVERAGE IN 6 MONTHS			
PAIN AT WORST LEVEL			

2. On a scale of 0 – 10, 0 = No Interference and 10 = Unable to Carry on Activities, how much has pain interfered with daily life?

   Please explain it interferes? _____

   _____

Was there a prior accident/fall/trauma to the area of pain? ◯ **YES** ◯ **NO** Explain: _____

Were there prior tests? ◯ **YES** ◯ **NO** Explain: _____

Was there prior treatments? ◯ **YES** ◯ **NO** Explain: _____

WHAT TYPE OF TREATMENT HAVE YOU HAD FOR THIS PAIN/PROBLEM?

Medicines: _____

Counseling: _____

Occlusal Adjustments: _____

Splint: Yes No How Many? _____

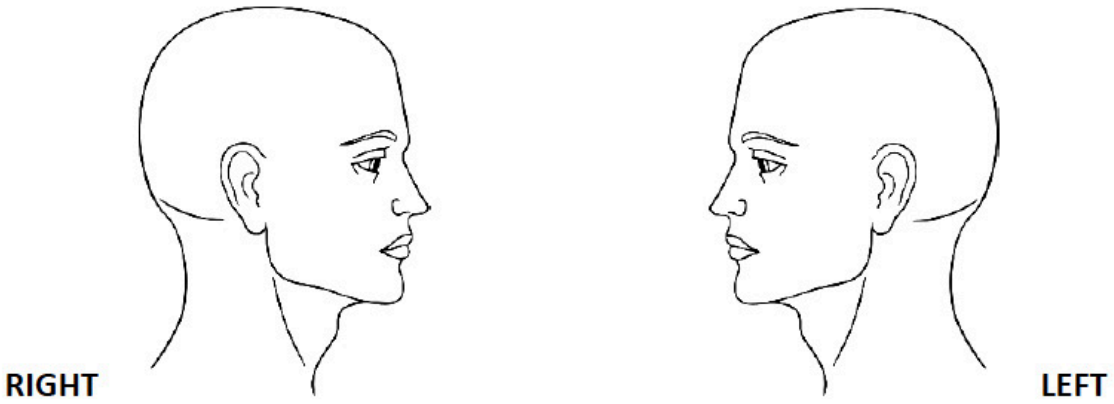
Orthodontics: _____

Physical Therapy: _____

Other: _____

DRAW ON THE IMAGES THE AREAS THAT ARE PAINFUL:

(If filling out on a computer, use space and enter keys to place an X over the area.)



ALL COMPLETED FORMS SHOULD BE EMAILED TO GREENVILLE@MYCENTERS.COM.