

Headache TMJ and Facial Pain Form

PATIENT'S NAME: _____

DATE: _____

BIRTH DATE: _____ **AGE:** _____ **M F** **MARITAL STATUS:** **S M W D**

OCCUPATION: _____

Chief Complaint (why are you here?):

History of Present Illness: (Give a brief description of how your problem started and how it progressed)

When did this begin?

What have you done to make it better? What treatment have you had? How effective was it?

ACCIDENT INFORMATION

Is your complaint associated with an accident? YES NO

Date(s) of Accident(s) _____

Please give a description of the accident:

List all CURRENT PAIN PRESCRIPTIONS & OVER THE COUNTER PAIN MEDICATIONS

Name and Dosage of medication	Medication taken for what condition?	Prescribing Doctor's Name (If applicable)	Number of times per day	How long have you been taking this medication?	Indicate amount of relief from condition: E =Excellent F =Fair M =Minimal N =None

List all **PAST PAIN PRESCRIPTIONS** and all **PAST OVER THE COUNTER PAIN MEDICATIONS**

Name and Dosage of Past Prescription medication	Medication taken for what condition?	Prescribing Doctor's Name	Number of times per day	How long had you been taking this medication? Why did you stop taking this medication?	Indicate amount of relief from condition E =Excellent F =Fair M =Minimal N =None

List all other **medications** you use:

Name of Referring Doctor: _____

Address: _____

Phone: _____

THE NAMES OF YOUR CAREGIVERS ARE:

Family Doctor: _____

Family Dentist: _____

Oral Surgeon: _____

Neurologist/ Neurosurgeon _____

Pain Management Physician: _____

Orthopedic Surgeon: _____

Cardiologist: _____

Physical Therapist: _____

ENT: _____

Psychiatrist: _____

Psychologist: _____

Other: _____

CIRCLE any of the below conditions that apply to you. Use the back of this sheet if you would like to explain further.

Headaches Nausea Vomiting Asthma Sinus Headaches Heartburn Stroke Chest Pain

Difficulty Swallowing Heart Trouble Jaw Pain Diarrhea High Blood Pressure Pregnant

Toothache Constipation Diabetes Sleep Apnea Arm / Calf Pain Arthritis

Snoring Heart Skipping / Racing Gout Weight Loss / Gain Mood Swings Seizures

Fever Significant Stress Mental Illness Fatigue (Lack of Energy) Easy Bruising Cancer

Double Vision Gums Bleed Easily Bleeding Disorders Blurred Vision Excessive Bleeding

Alcoholism Ringing in Ears Joint Pain / Stiffness Lung Disease Vertigo / Dizziness

Joint Swelling Tuberculosis Frequent Sore Throat Muscle Pain Phlebitis

Sinus Infections Back Pain Anemia Hearing Loss Seizures Stomach Ulcer

Loss of Smell Numbness / Tingling Liver Trouble Nasal Congestion Hesitant / Slurred Speech

Thyroid Trouble Urinary Problems Coldness of hands / feet Fibromyalgia

Hay Fever / Airborne Allergies Weakness of body part Sexual Disease Hives / Eczema

Trouble Walking Depression Shortness of Breath Rash / Sores / Lesions Sleep Disorder

Coughing Blood Changes in a mole Serious Injuries Persistent Cough Heat / Cold Intolerance

AIDS Stomach Pain Unusual Lumps Enlarged Glands Migraines High Cholesterol Other

List all allergies including medicines:

List All

Surgeries: _____

SOCIAL HISTORY

Do you smoke? Packs per day _____

Do you drink alcohol? Drinks per day: _____ Drinks per week: _____

Recreational Drugs? None: _____ Presently: _____ Past: _____

Caffeine Use: Drinks per day: _____

Caffeine Stimulant Use: _____ Tabs / week

1. Do you have **pain in your jaw** that is brought on by **jaw movement**, such as yawning and/or clenching? YES NO
2. Do you have **decreased ability to open your mouth** all the way? YES NO
3. Does your **jaw make noises** during mouth movements? YES NO
4. Does pushing on your **jaw joint(s)** with your fingers cause **pain**? YES NO
5. Do you **avoid tough** or chewy foods to minimize your jaw pain? YES NO
6. Do you **avoid opening** your mouth wide to avoid your jaw pain? YES NO
7. Have you taken **over the counter medications**, such as Advil, Tylenol, or Aleve to **reduce your jaw pain**, but the pain consistently remains or returns to full force? YES NO
8. Have you ever had **orthodontic** (braces) treatment? YES NO
9. Do you suffer with **poor sleep** or **sleep apnea** ? YES NO
10. Are you aware of **clenching** or **grinding** your teeth during the day or night? YES NO

HEADACHES

Do you suffer from regular **headaches** or **Sinus Headaches**? YES NO

When you have a headache, how often do you...

1. Have **Moderate to severe pain**? Never Rarely Usually Always
2. Have pulsating, pounding, or **throbbing** pain? Never Rarely Usually Always
3. Have worse pain on **one side** of your head? Never Rarely Usually Always
4. Have **worse pain** when you **move** or bend over? Never Rarely Usually Always
5. Have **nausea**? Never Rarely Usually Always
6. Have sensitivity to or are bothered by **light**? Never Rarely Usually Always
7. Have sensitivity to or are bothered by **sound**? Never Rarely Usually Always
8. Need to limit or **avoid daily activities**? Never Rarely Usually Always

9. Want to lie down in a quiet **dark room**? Never Rarely Usually Always

10. See visual disturbances, spots or **light flashes**? Never Rarely Usually Always

Do any **immediate family members** also suffer from headache? Please list _____ YES NO

In your lifetime, have you had at least **5** headaches with the symptoms you noted above? YES NO

When you have headaches, how often do you....

1. **Feel them coming on** before they become a headache? Never Rarely Usually Always

2. **Feel fed up** or irritated by your headaches? Never Rarely Usually Always

3. **Feel “drained”** or too tired to want to do daily activities? Never Rarely Usually Always

4. Feel a **reduced ability to concentrate**? Never Rarely Usually Always

At what **age** did you **first** experience these **headaches**? _____

Have you recently had an MRI or CAT Scan of your head? _____

I certify the above medical information is correct.

Signature: _____ **Date** _____