Orofacial Pain Questionnaire

INSTRUCTIONS

Please allow ample time to complete this questionnaire. It is very lengthy but all of the information requested is pertinent to your patient care.

The questionnaire must be completed prior to your arrival for your TMD appointment at Integrated Dental of Florida. Failure to complete the questionnaire prior to your appointment will mean that we will have to reschedule you for a new appointment time.

Should you have any questions, please do not hesitate to contact our office.

Integrated Dental of Florida
Melvin B. Benson Jr., DDS, FAGD
1435 S. Tamiami Trail, Suite B
Sarasota, FL 34239
(941) 256-3675
www.IDAFlorida.com

Integrated Dental of Florida
Orofacial Pain and TMD Questionnaire

Patient Name _____
First Middle Last Preferred

Address_____
Street City State Zip Code

Cell Phone (_____)_____ **May we call?** □ Yes □ No **Leave a Message?** □ Yes □ No

Home Phone (_____)_____ **May we call?** □ Yes □ No **Leave a Message?** □ Yes □ No

Work Phone (_____)_____ **May we call?** □ Yes □ No **Leave a Message?** □ Yes □ No

Email Address: _____ **May we email?** □ Yes □ No

Occupation: _____**Full-time Part-time**

Sex at birth: □ **Male** □ **Female** **Date of Birth:**___/___/_____ **Age:** _____

Marital Status: □ **Single** □ **Married/Living Together** □ **Separated**

□ **Divorced** □ **Widowed**

Name of Spouse/Significant Other: _____

Spouse's Occupation: _____**Phone:** _____

In Case of Emergency Contact: _____

Who Referred You to Our Practice?_____

Address: _____
Street City/State Zip Phone

The Referring Person is a: □ **Physician** □ **Dentist** □ **PhD** □ **Other**
****In addition we would like to have the name of your current physician, who will be involved in your care:**

Name _____

Address: _____

Phone_____**Fax** _____

Is your pain complaint/medical problem a result of an auto accident or work related injury? ☐ **Yes** ☐ **No**

1. **Briefly describe your current pain problem. Why exactly are you seeking care?**

   _____
   _____
   _____
   _____

2. **Circumstances under which your pain problem (s) began:**
   - **a. _____accident at work**
   - **b. _____accident at home**
   - **c. _____other accident**
   - **d. _____following illness**
   - **e. _____following surgery**
   - **f. _____at work(no accident)**
   - **g. _____at home(no accident)**
   - **i. _____no known cause**
   - **h. _____other _____**

3. **Briefly describe circumstances checked:**

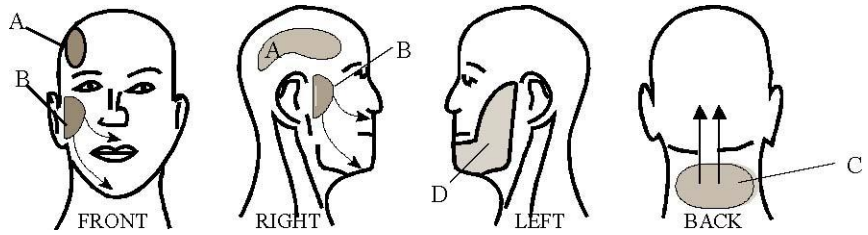
   _____
   _____

4. **What does your pain feel like? Some of the words below describe your present pain. Circle only those words that describe it. Leave out any category that is not suitable. Use only a <u>single word</u> in each appropriate category (the one that best applies).**

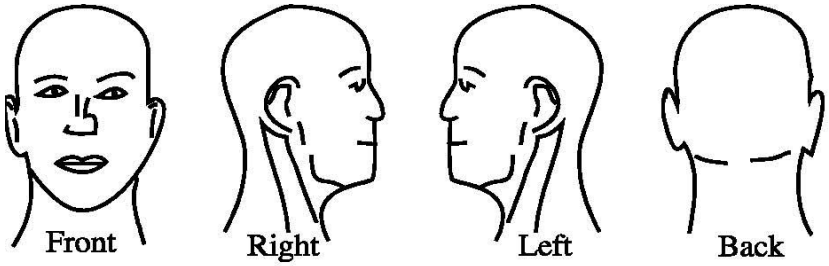
1	flickering quivering pulsing throbbing beating pounding	2	jumping flashing shooting	3	pricking boring drilling stabbing lancinating	4	sharp cutting lacerating	5	pinching pressing gnawing cramping crushing
6	tugging pulling wrenching	7	hot boring scalding searing	8	tingling itchy smarting stinging	9	dull sore hurting aching heavy	10	tender taut rasping splitting
11	tiring exhausting	12	sickening suffocating	13	fearful frightful terrifying	14	punishing grueling cruel vicious killing	15	wretched blinding
16	annoying troublesome miserable intense unbearable	17	spreading radiating penetrating piercing	18	tight numb drawing squeezing tearing	19	cool cold freezing	20	nagging nauseating agonizing dreadful torturing

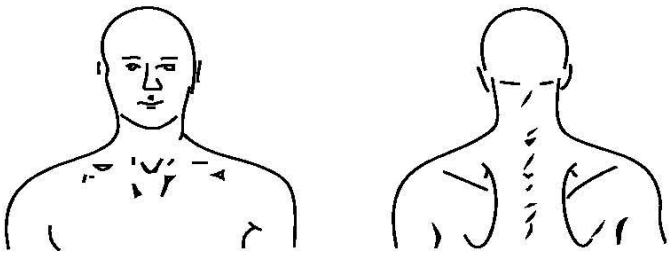
5. **On the diagrams, following the example below, mark the areas where you experience pain most frequently by shading, sketching, or outlining the painful areas in order of severity, with (A) being the most severe or distressing. If the pain frequently moves, mark the starting point (worst area) with an (X) and draw an arrow to where the pain moves.**

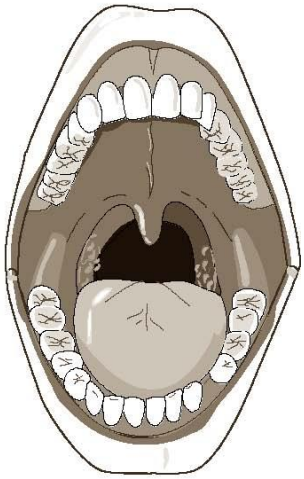
PLEASE <u>DO NOT USE THIS EXAMPLE</u> TO DRAW YOUR PAIN AREAS



Mark or draw *<u>YOUR</u>* area(s) of pain on the diagrams with a sharp pencil:







6. **How long have you had these pain complaints? (Approximate date of original onset):**

A._____ B._____ C._____ D._____

Has your pain increased, decreased, or remained the same since it began? (circle one)

Increased Decreased Remained the same

Comments:

_____

_____

7. **Each of the following questions is about your experience of pain. These questions can be answered by circling a word or words. If you wish to describe more than one head/face pain problem, list them individually in the area below (problems A, B, C, etc), listing your worst pain first. These are called your *CHIEF COMPLAINT(S): The problems for which you are seeking care here.**

PROBLEM A _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild	Sharp Dull Burning	___times/day	Seconds Minutes	Morning Afternoon
Moderate	Aching Shooting	___times/week	Hours Days	Night Variable
Severe	Tingling	___times/month	Constant	While eating, talking
	Other _____		Variable	As day progresses

PROBLEM B _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild	Sharp Dull Burning	___times/day	Seconds Minutes	Morning Afternoon
Moderate	Aching Shooting	___times/week	Hours Days	Night Variable
Severe	Tingling	___times/month	Constant	While eating, talking
	Other _____		Variable	As day progresses

PROBLEM C _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild	Sharp Dull Burning	___times/day	Seconds Minutes	Morning Afternoon
Moderate	Aching Shooting	___times/week	Hours Days	Night Variable
Severe	Tingling	___times/month	Constant	While eating, talking
	Other _____		Variable	As day progresses

PROBLEM D _____

Intensity	Type of Pain	Frequency	Duration	Worst time of Day
Mild	Sharp Dull Burning	___times/day	Seconds Minutes	Morning Afternoon
Moderate	Aching Shooting	___times/week	Hours Days	Night Variable
Severe	Tingling	___times/month	Constant	While eating, talking
	Other _____		Variable	As day progresses

8. **The following lines represent pain intensity.**
<u>Draw a mark on the line to best describe the intensity of your pain.</u>

Example: If you have pain that is on average midway between no pain at all and the most severe pain you have ever experienced, then you should place a vertical mark midway on the line.

no pain _____|_____ **most pain ever**

PLEASE COMPLETE THE FOLLOWING AS SHOWN IN THE EXAMPLE ABOVE:

a. **Your average pain level:**
no pain _____ **most pain ever**

b. **Your pain at its worst:**
no pain _____ **most pain ever**

c. **Your pain at its least:**
no pain _____ **most pain ever**

d. **Your pain at its least:**
no pain _____ **most pain ever**

THE FOLLOWING REPRESENTS YOUR PAIN ON CHEWING.

a. **Mark the line depicting your pain level:**
no pain _____ **most pain ever**

9. **Does your pain increase when you open wide? Yes No**
Where?
_____
_____

10. **If your pain is not constant, what events are most likely to make it start (what brings it on)?**
Problem A _____
Problem B _____
Problem C _____
Problem D _____

11. **What is most likely to make your general pain worse? (EXAMPLES: chewing, stress, sleep, talking, opening mouth wide, certain foods, weather, hot/cold food or drinks, exercise, lack of sleep, emotional upset, other…)**
<u>LIST IN ORDER OF SEVERITY (WORST FIRST)</u>
PROBLEM A _____
PROBLEM B _____
PROBLEM C _____
PROBLEM D _____

12. **What eases your general pain, or makes it better? (EXAMPLES: medication, sleep, vacation, massage, exercise, hot or cold compresses, relaxation, moving or holding jaw in a certain position)**
    List in order of effectiveness (most effective first)
    PROBLEM A _____
    PROBLEM B _____
    PROBLEM C _____
    PROBLEM D _____

13. **Is there anything that can make your pain go away?**
    _____

14. **How long on average can you go without pain, if at all?**
    _____

15. **Describe your longest period of complete relief.**
    _____

16. **Does anything occur or do you notice anything else when the pain is severe? For example, visual disturbances, nausea, perspiration, dizziness, tight chest, earache.**
    _____
    _____

17. **Since the onset of your problem, has your participation in the following activities decreased? If so…estimate percentage of pain interference in:**

		Description
Physical exercise	____%	_____
Leisure/social	____%	_____
Sleeping	____%	_____
Relationships	____%	_____
Housework & chores	____%	_____
Eating normal foods	____%	_____
Talking	____%	_____

18. **What other treatments have you had for your chief complaints and who was or is treating doctor or provider? Please provide short, concise answers since details may be discussed at your appointment.**

PROBLEM	TREATMENT	DOCTOR OR PROVIDER (Name and Specialty)

19. **Which of the treatments provided relief?**
Comments:_____
_____
_____

20. **What do you think is the cause of your pain?**
_____
_____

21. **What other painful or significant medical or dental conditions have you been treated for in the past two years (other than your present problem)?**
Examples: arthritis, ulcer, trauma, back pain, heart condition, diabetes, depression
a_____ **b**_____**c** _____

d _____**e**_____**f**_____

22. **List your most recent *hospitalizations or surgeries* (of any type):**

Date	Reason	Treatment

23. **Have you been or do you plan to be involved in legal action regarding your pain? ____Yes ____No**

Explain: _____
_____

24. **Please check health care providers you have seen or consulted for your present condition:**

__Acupuncturist	__ENT Physician	__Neurosurgeon	__Psychologist
__Allergest	__Endocrinologist	__Ophthalmologist	__Surgeon
__Anesthesiologist	__Family Physician	__Oral Surgeon	__Psychiatrist
__Chiropractor	__Gynecologist	__Dentist	__Internist
__Physical Therapist	__Rheumatologist	__Neurologist	__Other:_____
__Dermatologist	__Pain/Rehab Center		_____
__Pain/Rehab Center	___Orthopedic Surgeon		_____

26. Please list <u>all</u> medications *(<u>prescription and over the counter</u>)* and nutritional supplements that you are *<u>presently</u>* taking:

Prescription Medications	DOSE Morning	Noon	Evening	Bedtime	Total

Over-the Counter Medications	DOSE Morning	Noon	Evening	Bedtime	Total

Nutritional Supplements	DOSE Morning	Noon	Evening	Bedtime	Total

27. What is/are the most effective pain medication(s) you have utilized?

_____

_____

28. Describe any unusual reactions or allergies to any medications:

_____

_____

_____

29. Listed below are a number of drugs. Please circle the ones you have <u>taken within the last year other than those noted above:</u>

Anacin	Advil	Codeine	Benadryl	OTHER DRUGS:
Ascriptin	Anaprox	Darvon	Butazolodin	_____
Asprin	Ibuprofen	Darvocet	Decadron	_____
Bufferin	Lodine	Demerol	Hydrocortisone	_____
Empirin	Naprosyn	Equagesic	Methotrexate	_____
Excedrin	Relafen	Fioricet	Prednisone	_____
Norgesic	Toradol	Lorcet	Dilantin	_____
Parcogesic	Ultram	Lortab	Compazine	_____
Phenaphen	Methadone	Percocet	Haldol	_____
Tylenol	Skelaxin	Beconase	Baclofen	_____
Percodan	Periactin	Prozac	Soma	_____
Robaxin	Antibiotics	Neurontin	Klonopin	_____
Tavist	Ativan	Cafergot	Valium	_____
Vicodin	Calan	Zoloft	Restoril	_____
Buspar	Midrin	Paxil	Serax	
Dalmane	Inderal	Nardil	Drixoral	
Flexeril	Verapamil	Parnate	Tofranil	
Halicon	Imitrex	Elavil	Tranxene	
Meprobamate	DHE 45	Deseryl	Recreational Drugs:	
Norpramin	Librium	Tegretol	___Yes ___No	

30. How often do you exercise?_____

31. What type of exercise do you participate in?

_____

32. When you use the following, how much do you take in a day?

Coffee ____ cups/day	tobacco _____ cigarettes/day	other _____
Cola _____ glasses/day	beer _____12 oz. cans/day	_____
Wine _____ glasses/day	liquor _____oz/day	_____

33. Does you condition awaken you from or prevent sleep?
Yes _____ No _____
Describe: _____

34. Do you feel you get adequate sleep? Yes ___ No ___
How many hours a night? _____

35. Do you feel rested after sleeping? Yes ___ No ___

36. Are you a restless sleeper? Yes ___ No ___

37. Are you generally(circle one) calm and relaxed tense and uptight

A. Are you feeling depressed? Yes No

B. Are you feeling anxious? Yes No

C. Are there major stressor in your life? Yes No

If you answered yes to any of the above (A,B,C) please explain briefly:

A. _____

B. _____

C. _____

38. Does an increase in stress, anxiety or depression seem to make your pain worse? Yes ___ No ___ Please explain:

_____

_____

39. Have you noticed clenching or grinding your teeth or other oral habits that increase pain? Yes ___ No ___

When? Under stress or tension _____ While sleeping _____
Other _____

Describe: _____

40. Do you feel that clenching or grinding your teeth causes or contributes to your pain? Yes ____ No ____ Sometimes _____

41. Have you experienced any of the following:

__divorce __marriage __re-marriage

__relocated/moved __job change __job dissatisfaction

__separation from spouse __being fired __financial troubles

__Abuse: emotional, physical, sexual __problems with children

__death of friend or loved one __serious illness friend or loved one

__chemical or alcohol dependency __other

42. Do you think you drank more beer, wine, or liquor in the past year because of your pain? ___ Yes ___ No

If yes, what?

_____

43. Have you ever been told you have a problem with alcohol or drugs?
_____ Yes _____ No

44. How would you describe your marital relationship now?

a. __very satisfactory c. __ unsatisfactory

b. __ satisfactory d. __ very unsatisfactory

45. Do you have family member(s) or close friend(s) who has or has had a pain problem? ___Yes ___No If so, what type?

_____

46. What would you be able to do differently if you were out of pain?

_____

_____

47. What percentage of pain relief would be acceptable from treatment?

_____

_____

48. Have you considered what you would do in the event that your pain would not be eliminated or significantly improved?

_____

_____

49. What are you willing to do to improve?

_____

_____

50. What are you <u>not</u> willing to do to improve?

_____

_____

Patient Signature: **Date:**

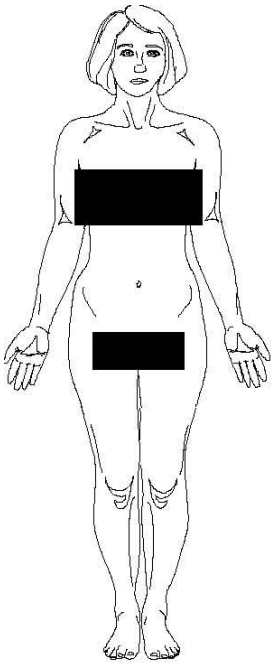
_____ _____

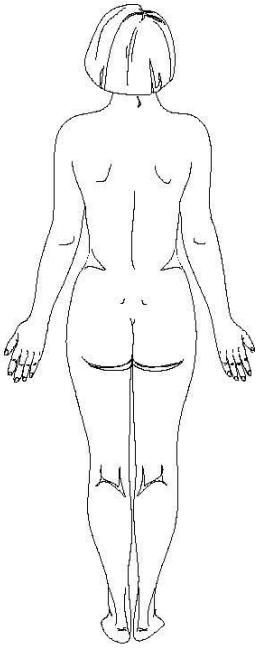
Doctor Signature: **Date:**

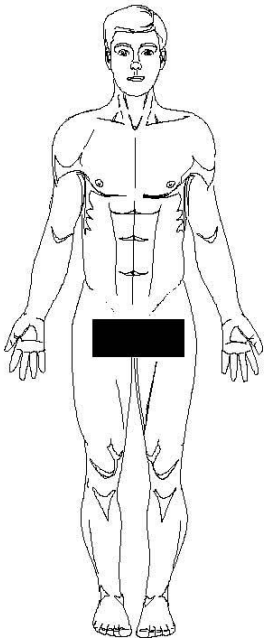
_____ _____

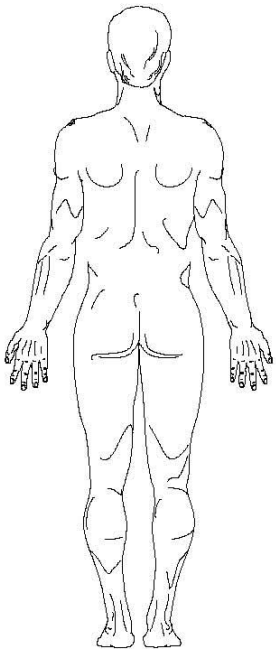
On the "full body" diagrams below, indicate *<u>other areas</u>* where you commonly have significant pain not discussed above.

Number the areas in order of intensity, the worst area being #1, and so on. Provide a brief description please, and note how long these pain conditions have been present, and if they were in the past or are currently under the care of a physician, chiropractor, etc.









How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____