Pacific Oral Medicine
Name: _____
Date of Birth: _____ Medical Record#: _____

- PLEASE READ THE FOLLOWING INFORMATION CAREFULLY –

Dear Patient: This questionnaire will ask you a large number of questions about your past medical and dental problems, current diseases, and present symptoms that may indicate medical or dental disorders which warrant additional evaluation. To provide you with the best care, we need to understand all aspects of your health. Please answer these questions as accurately as possible and ask for assistance if you do not understand a question. All information in your medical record is private and will be held confidential.

1. GENERAL INFORMATION

Name: _____ _____ Gender ○ Male
LAST FIRST ○ Female

Date of Birth: _____ Weight: _____lbs/Kg Height: _____ft/cm

Address: _____

City: _____ ZIP: _____

Telephone: Home: _____ Email: _____

Bus: _____ Occupation: _____

Other: _____

What is the highest grade or year of regular school that you have completed?

Elementary School or less ○

High School (indicate grade) ○ 9 ○ 10 ○ 11 ○ 12

College (indicate degree) _____

What is your marital status?

- ○ Married – spouse in household
- ○ Married – spouse not in household
- ○ Widowed
- ○ Divorced
- ○ Separated
- ○ Never Married

Current Living Situation – Living with:

- ○ Other adult(s) How many? _____
- ○ Child(en) How many? _____
- ○ Alone

Which of the following groups best represents your race?

- ○ Aleut, Eskimo or American Indian
- ○ Asian or Pacific Islander
- ○ Black
- ○ White
- ○ Other (Please specify) _____

Are any of these groups your national origin or ancestry?

- ○ Puerto Rican
- ○ Cuban
- ○ Mexican/Mexicano
- ○ Mexican/Americano
- ○ Chicano
- ○ Other Latin American
- ○ Other Spanish
- ○ None of the above

ASSESSMENT AND TREATMENT HISTORY

2. Your Healthcare Providers

a. Who were you referred by? Physician ⬭ Dentist ⬭ Other ⬭ _____

b. Have you ever gone to a physician, dentist chiropractor, or other health professional for your oral complaint?
⬭ No
⬭ Yes, in the last 6 months
⬭ Yes, more than 6 months ago

c. IF YES, please list who you saw and the outcome of the visit(s). _____

_____

_____

_____

d. Estimate the total number of health care visits you have ever made for your oral complaint: _____

e. What diagnostic tests have you had for your oral complaint?
⬭ Clinical Exam ⬭ MRI/CT Scan
⬭ Dental X-rays ⬭ Tomograms
⬭ Bone Scan ⬭ Other_____

3. CONTACT INFORMATION

***It is important that we have all of your healthcare provider(s) contact information so that if needed we can easily access any pertinent tests or examinations ordered by these other medical practitioners.**

Primary MD: First Name _____ Last Name_____Tel._____Fax_____

Address _____City/State _____ Zip _____

Family Dentist: First Name _____Last Name _____Tel. _____Fax _____

Address: _____ City/State _____ Zip _____

Specialists:

First Name _____ Last Name _____ Speciality: _____ Tel. _____Fax_____

Address _____ City/State _____Zip _____

First Name _____ Last Name _____ Speciality: _____ Tel. _____Fax_____

Address _____ City/State _____Zip _____

First Name _____ Last Name _____ Speciality: _____ Tel. _____Fax_____

Address _____ City/State _____Zip _____

First Name _____ Last Name _____ Speciality: _____ Tel. _____Fax_____

Address _____ City/State _____Zip _____

Pharmacy Name _____ Fax _____ Tel _____

3. PROBLEM HISTORY

Indicate the problems and pain for which you are seeking treatment.

PAIN	JAW JOINTS	MOUTH, FACE & NECK	SENSATIONS
⬭ Mouth	⬭ Swelling	⬭ Swelling	⬭ Numbness
⬭ Teeth	⬭ Clicking/popping	⬭ Lump or growth	⬭ Burning
⬭ Jaws	⬭ Locking	⬭ Redness, warmth	⬭ Tingling
⬭ Joints (jaw)	⬭ Grinding	⬭ Infection	
⬭ Face	⬭ Pressure	⬭ Bite change	
⬭ NONE OF THE ABOVE			

4. DESCRIBE YOUR PROBLEM

a. Describe the problem for which you are seeking treatment.

b. Since you first noticed the problem, Do you consider yourself:
⬭ Worse
⬭ Same
⬭ Better

c. Have you had pain in the face, jaw, temple, in front of the ear, or in the ear in the past month?
⬭ No
⬭ Yes

5. WHERE IS YOUR PAIN LOCATED?

⬭ ***** - Mark this circle and skip to question #10 if you are not seeking treatment for pain.
R – Right side; L – Left

HEAD & NECK						MOUTH			OTHER		
R	L		R	L		R	L		R	L	
		Forehead			TM Joint			Extraction Site			Scalp
		Temple			Muscle			Denture Ridge			Eye
		Cheek			Face			Gum Tissue			Shoulder
		Sinus			Ear			Tongue			Back
		Upper Jaw			Throat			Upper Teeth			Arm
		Lower Jaw			Neck			Lower Teeth			Chest

***** The questions that follow will ask you about facial pain. This pain includes pain of the face, jaws, jaw joints, facial muscles and mouth.

6. a. How many years ago did your facial pain begin for the first time? _____ Years
b. IF LESS THAN 1 YEAR, How many months ago did your facial pain begin for the first time? _____Months

7. Is your facial pain persistent, recurrent
Or was it only a one time problem?
⬭ Persistent
⬭ Recurrent
⬭ One – Time

8. WHAT DOES YOUR FACIAL PAIN FEEL LIKE? ⬭ **Mark here if you have no present pain**

Some of the words below may describe your PRESENT pain. Indicate ONLY those words that best describe it.

⬭ Throbbing	⬭ Unbearable	⬭ Aching	⬭ Pulling
⬭ Shooting	⬭ Burning	⬭ Exhausting	⬭ Terrifying
⬭ Sickening	⬭ Tiring	⬭ Stabbing	⬭ Cutting
⬭ Sharp	⬭ Tender	⬭ Fearful	⬭ Annoying
⬭ Gnawing	⬭ Punishing	⬭ Splitting	⬭ Stinging
⬭ Cramping	⬭ Heavy	⬭ Cruel	⬭ Hot

9. PAIN

Rate your facial pain according to the 0 to 10 scales below.

a. How would you rate your facial pain on a 0 to 10 scale AT THE PRESENT TIME, that is right now, where 0 is "no pain" and 10 is "pain as bad as it could be"?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7 ⬭ 8 ⬭ 9 ⬭ 10
No Pain — Pain is bad as it could be

b. In the PAST SIX MONTHS, how intense was your WORST pain?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7 ⬭ 8 ⬭ 9 ⬭ 10
No Pain — Pain is bad as it could be

c. In the PAST SIX MONTHS, on the AVERAGE, how intense was your pain? (That is, your usual pain at times you were experiencing pain?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7 ⬭ 8 ⬭ 9 ⬭ 10
No Pain — Pain is bad as it could be

10. PAIN FREQUENCY

a. On about how many days have you had face or jaw pain in the PAST SIX MONTHS? _____ DAYS
(Every day for the past 6 months = 180 days)

b. On days you've had face or jaw pain in the PAST SIX MONTHS, how many hours were you usually in pain? _____HOURS

11. a. Have you had a recent injury to your face or jaw? ○ Yes ○ No

b. IF YES, did you have jaw pain before the injury? ○ Yes ○ No

c. IF NO, have you ever had an injury to your face or jaw. ○ Yes ○ No

12. a. Have y o u had or do you have any swollen or painful joint (s) other than the joints close to your ears (TMJ)? ○ Yes ○ No

. b. IF YES, is this a persistent problem that you have had for at least one year? ○ Yes ○ No

13. On the list below for each treatment prescribed for your jaw problem, indicate how helpful you've found it.

	Never Prescribed	**Very Helpful**	**Somewhat Helpful**	**Not Helpful**	**Made Worse**	**Did not do Treatment**
Mouth Appliance (bite plate, night guard, repositioning appliance, splint)						
Physical Therapy (heat, cold packs, stretching						
Relaxation Training/Bio Feedback						
Physical Exercise (running, bicycling, swimming)						
Stress Management/Counseling						
Change of Diet						
Muscle Relaxant Medication						
Analgesics or "pain killers"						
Anti-inflammatory Medications						
Anti-depressant Medications						
Anti-anxiety Medications						
Other Medications (please describe):						
Bite Adjustment						
Orthodontics						
Dental Reconstruction (crown, bridges)						
Muscle or Joint Injections						
Surgery						
Chiropractic Manipulation						
Evaluation and/or Referral						
Other Treatment (please describe)						

14. Have you ever had a mouth appliance (i.e. Splint, Night guard, Bite guard) made for the control of facial pain? **IF NO, skip to question 15.**

- ⬭ Yes
- ⬭ No

IF YES…

b. How many appliances have you had?

- ⬭ 1
- ⬭ 2
- ⬭ 3
- ⬭ 4
- ⬭ 5

c. When was the last time you used a mouth appliance for management of facial pain?

- ⬭ In the past day
- ⬭ In the past week
- ⬭ In the past month
- ⬭ In the past 3 months
- ⬭ More than 3 months ago

d. Are you COMPLETELY Satisfied with your current appliance

- ⬭ No
- ⬭ Yes

15. During the past six months, how often have you had each of the following jaw symptoms?

HOW OFTEN…..	**Never**	**Sometimes**	**Often**	**Always**
a. Does your JAW CLOCK OR POP when you open or close your mouth or when chewing?	⬭	⬭	⬭	⬭
b. Does your jaw make a GRATING OR GRINDING noise when it opens and closes when chewing?	⬭	⬭	⬭	⬭
c. Does your JAW JOINT NOISES prevent you from doing activities that you would otherwise do?	⬭	⬭	⬭	⬭
d. Does your JAW ACHE OR FEEL STIFF when you wake up in the morning?	⬭	⬭	⬭	⬭
e. Does your JAW HURT WHEN YOU CHEW or shortly after eating?	⬭	⬭	⬭	⬭
f. Does ache or PAIN in your jaw LIMIT your ABILITY TO CHEW to the extent that it is difficult to eat?	⬭	⬭	⬭	⬭
g. Do you wake up in the morning with HEADACHES?	⬭	⬭	⬭	⬭
h. Do you have NOISES OR RINGING in your EARS?	⬭	⬭	⬭	⬭
i. Do your EARS feel CONGESTED?	⬭	⬭	⬭	⬭
j. Have you been told, or do you notice that you GRIND your teeth or CLENCH your jaw WHILE SLEEPING at night?	⬭	⬭	⬭	⬭
k. Does limited ability to use your jaws PREVENT you from doing ACTIVITIES that you would otherwise do?	⬭	⬭	⬭	⬭
l. Have you ever had your JAW LOCK or CATCH so that it won't open all the way? (IF NEVER, go to question "n").	⬭	⬭	⬭	⬭
m. Was this limitation in jaw opening severe enough to interfere with your ABILITY TO EAT?	⬭	⬭	⬭	⬭

1**5 cont.** During the past six months, how often have you had each of the following jaw symptoms?

HOW OFTEN…..	**Never**	**Sometimes**	**Often**	**Always**
n. Have you ever had your jaw lock or catch so that YOU CAN'T CLOSE IT ALL THE WAY once it's open?	⬭	⬭	⬭	⬭
o. During the day, do you GRIND your teeth or CLENCH your jaw?	⬭	⬭	⬭	⬭
p. Does your BITE feel UNCOMFORTABLE or unusual?	⬭	⬭	⬭	⬭

16. a. Was the cause of your pain or jaw limitation related to any of the following factors? Do any of the following factors make your problem WORSE? For each of the items listed below, place a check mark under CAUSE or WORSE for each one that applies to your facial pain problem.

CAUSE	WORSE	PHYSICAL FAC TORS	CAUSE	WORSE	ORAL FUNCTION, HABIT & BEHAVIORAL FACTORS	CAUSE	WORSE	STRESS-RELATED
		*Dental Medical Treatment Date:			Chewing			Family
					Yawning/Opening wide			
		*Motor Vehicle Accident Date:			Speaking			Work
					Coughing			
		*Other accident Date:			Smiling/Laughing			School
					Clenching Teeth			
		*Surgery; date			Gritting/grinding teeth (day)			Other stress (please describe)
		*Head trauma; date:			Gritting/grinding teeth (night)			
		*Assault/Abuse; date:			Tensing shoulders/neck			Worry or anxiety (explain)
		Bite Problems			Nail Biting			
		Arthritis			Other oral habits			Feeling "blue"/Depression
		Chronic neck problems			Lack of sleep			
		Other medical problems (describe):						

b. *If those marked by an asterisk was a cause, did the problem begin: ⬭ Immediately ⬭ Delayed Onset

c. Are there any causes for your problem NOT listed in the above table? If so, please describe:

_____

_____

_____

17. People who have facial pain or limitations in jaw function often say that their problem is related to some combination of 1) physical factors, 2) behaviors (including oral habits and jaw posturing), and 3) stress and emotional upset.

a. Overall, how important were the following factors in originally causing your facial pain problem?

	Not at all Important	Moderately Important	Extremely Important	Don't Know
1) Physical Factors	⬭	⬭	⬭	⬭
2) Behavioral Factors	⬭	⬭	⬭	⬭
3) Stress and Emotional Upset	⬭	⬭	⬭	⬭

b. Overall, how important are the following factors in aggravating (making worse) your facial pain problem?

	Not at all Important	Moderately Important	Extremely Important	Don't Know
1) Physical Factors	⬭	⬭	⬭	⬭
2) Behavioral Factors	⬭	⬭	⬭	⬭
3) Stress and Emotional Upset	⬭	⬭	⬭	⬭

c. Overall, how important will it be for your treatment program to include treatments for:

	Not at all Important	Moderately Important	Extremely Important	Don't Know
1) Physical Factors	⬭	⬭	⬭	⬭
2) Behavioral Factors	⬭	⬭	⬭	⬭
3) Stress and Emotional Upset	⬭	⬭	⬭	⬭

18. Are your symptoms better or worse at the following times?

	Better	Worse	No Difference
Upon Awakening	⬭	⬭	⬭
During the day	⬭	⬭	⬭
At work	⬭	⬭	⬭
At home	⬭	⬭	⬭
In the evening	⬭	⬭	⬭

19. What activities do your present jaw problem prevent or limit you from doing?

	No	Yes		No	Yes
Chewing	⬭	⬭	Swallowing	⬭	⬭
Drinking	⬭	⬭	Cleaning teeth or face	⬭	⬭
Exercising	⬭	⬭	Yawning	⬭	⬭
Eating hard foods	⬭	⬭	Sexual Activity	⬭	⬭
Eating soft foods	⬭	⬭	Talking	⬭	⬭
Smiling/laughing	⬭	⬭	Having your usual Facial appearance	⬭	⬭

20. PAIN IMPACT

a. About how many days in the LAST SIX MONTHS have you been kept from your usual activities (work, school, housework) because of facial pain? (Every day for the last 6 months = 180 days) _____ Days.

b. In the PAST SIX MONTHS, how much has facial pain interfered with your daily activities rated on a scale from 0 to 10 where 0 is "No Interference" and 10 is "Unable to carry on any activities"?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7 ⬭ 8 ⬭ 9 ⬭ 10
No interference — Unable to carry on any activities

c. In the PAST SIX MONTHS, how much has facial pain interfered with your ability to take part in recreational, social and family activities?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7 ⬭ 8 ⬭ 9 ⬭ 10
No interference — Unable to carry on any activities

d. In the PAST SIX MONTHS, how much has facial pain interfered with your ability to work (including housework)?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7 ⬭ 8 ⬭ 9 ⬭ 10
No interference — Unable to carry on any activities

e. Based on all the things you do to cope or deal with your facial pain, on an average day, how much control do you feel you have over it?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6
No control — Some control — Complete control

f. Based on all of the things you do to cope or deal with your facial pain, on an average day, how much are you able to decrease it?

⬭ 0 ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6
Can't decrease it at all — Can decrease it somewhat — Can decrease it completely

GENERAL MEDICAL INFORMATION

21. Would you say your health in general is ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor?
22. How well do you feel you are taking care of your health overall? ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor?

23. Has there been a change in your general health in the past year? ○ No ○ Yes
IF YES, please explain:

_____

_____

24. DATE OF YOUR LAST PHYSICAL EXAMINATION: _____/_____/_____

25. CURRENTLY UNDER TREATMENT BY A PHYSICIAN? ○ No ○ Yes

26. Do you engage in regular exercise? ○ No ○ Yes

MEDICAL HISTORY

27. PAST ILLNESS/ILLNESSES THAT YOU HAVE NOW

Have you ever been treated for the following:

Now	Past		Now	Past		Now	Past	
○	○	Cancer	○	○	Injury to face/jaw./neck	○	○	Kidney Disease
○	○	If yes, Chemotherapy? Radiation therapy?	○	○	Fractures	○	○	Bladder Disease
○	○	Genetic (inherited disease)	○	○	Concussion	○	○	Urethritis
○	○	Leukemia	○	○	Arthritis	○	○	Liver disease
○	○	Lymphoma	○	○	Headache	○	○	Rheumatic fever
○	○	Organ Transplant	○	○	Migraine	○	○	Scarlet fever
○	○	Rheumatoid Arthritis	○	○	Back Pain	○	○	Polio
○	○	Lupus erythematosus	○	○	Abdominal pain	○	○	Strep throat
○	○	Other systemic arthritic disease	○	○	Herpes Zoster	○	○	Mononucleosis
○	○	Diabetes	○	○	Fungal Infections	○	○	Hepatitis
○	○	Thyroid Problems	○	○	Other skin diseases	○	○	Venereal disease
○	○	Hormone Disorder	○	○	Gastric ulcer	○	○	Genital/anal warts
			○	○	Colitis	○	○	Genital Herpes

27. Cont.

Now	Past		Now	Past		Now	Past	
☐	☐	High Blood Pressure	☐	☐	Pancreatitis	☐	☐	Psychiatric illnesses
☐	☐	Arteriosclerosis	☐	☐	Gastritis	☐	☐	Anxiety/Panic attacks
☐	☐	Heart Attack/myocardial infarction	☐	☐	Crohn's Disease	☐	☐	Depression
☐	☐	Angina/Chest pain	☐	☐	Coeliac Sprue	☐	☐	Suicide attempt or thoughts
☐	☐	Heart Murmur	☐	☐	Gall bladder problems			
☐	☐	Heart Valve Problems	☐	☐	Splenectomy	☐	☐	Physical/sexual/ emotional abuse
☐	☐	Other heart disease	☐	☐	Irritable Bowel Syndrome			
☐	☐	Bleeding disorder	☐	☐	Emphysema	☐	☐	Drug abuse
☐	☐	Anemia	☐	☐	Pneumonia	☐	☐	Alcohol abuse
☐	☐	Epilepsy/seizures	☐	☐	Bronchitis	☐	☐	Prosthetic valve/joint
☐	☐	Neuralgia	☐	☐	Sinusitis	☐	☐	Require antibiotic medication
☐	☐	Stroke	☐	☐	Hay fever	☐	☐	Contact lenses
☐	☐	Other Neurological Problems	☐	☐	Asthma	☐	☐	HIV Infection
☐	☐	Glaucoma	☐	☐	Tuberculosis	☐	☐	AIDS
						☐	☐	Other immune diseases

28. WOMEN ONLY

Have you had …		Are you …	
Difficulty pregnancy	☐	Using birth control pills	☐
Irregular pregnancy	☐	PRESENTLY PREGNANT, IF YES, how many months:	☐ _____
Menstrual pains	☐	Going through menopause	☐
A hysterectomy	☐	Postmenopausal	☐
Ovary(ies) removed	☐	Using hormone therapy	☐

29. CURRENT ILLNESSES/REVIEW OF SYMPTOMS

Do you have any of the following:

Positive Cancer History	Describe type, location and treatment:
Neurological Disease	Describe any neurological abnormality (loss of muscle control, trembling, numbness/tingling, paralysis, handwriting changes, memory changes, neuropathy):
Cardiovascular Disease	Shortness of breath with exertion; racing or irregular heartbeat; swollen ankles; cold ankles/feet; Chest pain/angina; Other:
Dermatologic Disease	Skin changes (color); Skin Rash; itching/burning; Skin Cancer; Psoriasis, nail changes, Other:
Gastrointestinal Disease	Indigestion, Irritable Bowel Syndrome, Reflux/Heartburn: nausea/vomiting; constipation; diarrhea; Crohn's Disease, Abdominal pain; Other:
Headache and Neck	Migraine, Cluster, Tension Type Headaches; neck pain, neck lumps/swelling; facial pain; Other:
Nose & Throat	Congested/runny nose; Nose bleeds; Nasal obstruction; Sore throat; Hoarseness/voice changes; Mouth breathing; Congestive Heart Failure; Coughing Blood; Other:
Respiratory	Coughing/spells, cough up phlegm, wheezing, frequent colds, use more than 2 pillows to sleep; difficulty breathing; Congestive Heart Failure; Coughing Blood, Other:
Musculoskeletal	Joint pain; Swollen joints; muscle cramping; arm/hand weakness; Osteoporosis; Paralysis; Bone Disease; Other:
Hematologic Disorder	Anemia; Leukemia; Hemophilia; Bruising or Bleeding Problems (describe):

29 cont. CURRENT ILLNESSES/REVIEW OF SYMPTOMS

Do you have any of the following:

Metabolic Abnormality	Nutritional Deficiency; Inborn Metabolic disorder (describe):
Mental Status	Anger; Worry; Sleep difficulties; Reduced social activities; problems at work, home, school, Phobia, Depression; Anxiety Disorder; Schizophrenia, Other (describe):
Eyes & Ears	Vision changes; Eye itching; Dry eyes; Eye pain; Other: Hearing loss; Ringing ears; earaches; dizziness; pressure/stuffiness in ears; Other:
Endocrine	Thyroid Disease; Pregnant; Passing through or have you passed through menopause; Other: (describe)
General	Weight loss, Weight gain, Loss of appetite; Always hungry; Always thirsty; Frequent urination; Urinary difficulty; Tend to feel hot; Tend to feel cold; Fatigue; Faint easily; Night sweats; or OTHER (describe):

30. MAJOR HOSPITALIZATIONS, SURGERIES AND BLOOD TRANSFUSIONS

DATE			REASON
Day	Month	Year	

31. ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING?

- ⬭ Penicillin
- ⬭ Sulfa
- ⬭ Aspirin
- ⬭ Opiates/Codeine
- ⬭ Iodine
- ⬭ Other Drugs: _____
- ⬭ Local Anesthesia
- ⬭ Latex

List other allergies (food, metals, etc)

1. _____
2. _____
3. _____

32. MEDICATIONS

List medications you have been prescribed that you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List current non-prescription medications you use (e.g., aspirin, laxatives, antacids, diet pills, vitamins, herbal supplements, etc.) How frequently do you use them?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

33. CONSUMPTION OF BEVERAGES AND OTHER SUBSTANCES FOLLOWING:

a. Average number of caffeinated beverages you drink in a day:

Coffee ⬭ 0 ⬭ 1-2 ⬭ 3-5 ⬭ 5+

b. Average number of alcoholic beverages you drink in a week:

Beer ⬭ 0 ⬭ 1-2 ⬭ 3-5 ⬭ 6-10 ⬭ 10+

c. Have you ever used tobacco products?

⬭ No ⬭ Yes

IF YES, what types?

- ⬭ Cigarette
- ⬭ Pipe Cigar
- ⬭ Smokeless

33. cont. CONSUMPTION OF BEVERAGES AND OTHER SUBSTANCES FOLLOWING:

a. Average number of caffeinated beverages you drink in a day:

Tea ○ 0 ○ 1-2 ○ 3-5 ○ 5+

Cola ○ 0 ○ 1-2 ○ 3-5 ○ 5+

b. Average number of alcoholic beverages you drink in a week:

Wine ○ 0 ○ 1-2 ○ 3-5 ○ 6-10 ○ 10+

Spirits/ Other ○ 0 ○ 1-2 ○ 3-5 ○ 6-10 ○ 10+

c. Do you currently use tobacco products? ○ No ○ Yes

IF YES, average number per day: _____

How many years have you used A tobacco product? _____

d. Are you currently using any street or recreational drugs? ○ No ○ Yes

e. Do you use any prescription drugs not prescribed for you or medications that have been prescribed for someone else? ○ No ○ Yes

34. FAMILY MEDICAL HISTORY

Darken the circle beside medical problems that have been present in your parents, brothers/sisters, or close relatives.

○ Cancer (type: _____)	○ Anemia	○ Neurological disease	○ Lupus erythematosus
○ Genetic inherited disease	○ Bleeding disorders	○ High blood pressure	○ Other systemic arthritic Disease: _____
○ Stomach/intestinal problems	○ Allergic disorders	○ High cholesterol	
○ Kidney or bladder problems	○ Asthma	○ Heart disease	○ Other immune Systemic disease
○ Liver disease	○ Tuberculosis	○ Stroke	○ Drug abuse
○ Diabetes	○ Arthritis	○ Malocclusion (bad bite)	○ Alcoholism
○ Thyroid problems	○ Back pain	○ TMJ problems	○ Psychiatric illness
	○ Headaches or migraine	○ Rheumatoid arthritis	○ Anxiety/panic attack
	○ Seizures		

35. PREVIOUS DENTAL CARE

a. Darken the circle beside items that describe your **past dental care**.

○ Regular dental care	○ Wisdom teeth extractions	○ Gum disease (pyorrhea) Gingivitis, or periodontal disease	○ Bite adjustment
○ Only Emerg. Treatment	○ Treatment for jaw/trauma fracture	○ TMJ problems	○ Night guard/splint
○ Occasional dental care	○ Facial pain	○ Oral/Periodontal Surgery	○ Orthodontics

35. cont. PREVIOUS DENTAL CARE

b. Would you say your ORAL HEALTH in general is ⬭ Excellent ⬭ Very Good ⬭ Good ⬭ Fair ⬭ Poor

c. How good a job do you feel you are doing in taking care of your oral health? ⬭ Excellent ⬭ Very Good ⬭ Good ⬭ Fair ⬭ Poor

d. Date of last regular dental visit: _____

36. SYMPTOM CHECKLIST * Check those symptoms which best apply to you

In the last month how much have you been distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Headaches					
b. Nervousness/ shakiness inside/ restlessness					
c. Faintness or dizziness					
d. Loss of sexual interest or pleasure					
e. Pain in the heart or chest					
g. Feeling low in energy or slowed down					
h. Sleep that is restless or disturbed					
i. Trembling					
j. Poor appetite					
k. Crying easily					
l. Feeling of being caught or trapped					
m. Suddenly being scared/ spells of terror or panic					
n. Blaming yourself for things					
o. Pains in the lower back					
p. Feeling lonely					
q. Feeling blue					
r. Worrying too much about things					
s. Feeling no interest in things					
t. Feeling tearful					
u. Heart pounding or racing					
v. Nausea or upset stomach					
w. Soreness of your muscles					
x. Trouble falling asleep/Awakening early in the morning					
y. Difficulty making decisions					
Z. Trouble getting your breath					
aa. Hot or cold spells					
bb. Numbness or tingling in parts of your body					
cc. A lump in your throat					
dd. Feeling hopeless about the future/feeling of worthlessness/thoughts of death					
ee. Feeling weak in parts of your body					
ff. Feeling tense/keyed up or restless					
gg. Heavy feelings in your arms or legs					
hh. Overeating					
ii. Feelings of guilt					
jj. Feeling everything is an effort					
kk. The feeling that something bad is going to happen to you					
ll. Thoughts and images of a frightening nature					
mm. The idea that something serious is wrong with your body					
nn. The idea that something serious is wrong with your mind					

37. STRESS

a. How much stress have you experienced in the PAST MONTH as a result of:

	None	A Little	Some	A Great Deal
Home or family concerns	⬭	⬭	⬭	⬭
Work or school concerns	⬭	⬭	⬭	⬭
Financial concerns	⬭	⬭	⬭	⬭
Social or personal relationships	⬭	⬭	⬭	⬭
Health concerns	⬭	⬭	⬭	⬭
In general, how much stress have you experienced in the past month?	⬭	⬭	⬭	⬭

b. In the left hand column, mark any of the events listed below which have happened to you in the LAST YEAR. For each event marked, indicate whether the event had a positive impact, a negative impact or no impact on you.

	Positive	Negative	No Impact
⬭ Change in residence	⬭	⬭	⬭
⬭ Change in marital status (marriage, divorce, separation)	⬭	⬭	⬭
⬭ Change in living arrangement	⬭	⬭	⬭
⬭ Gain or loss of employment	⬭	⬭	⬭
⬭ Retirement of self or spouse	⬭	⬭	⬭
⬭ Birth in the family	⬭	⬭	⬭
⬭ Death of a close friend or relative	⬭	⬭	⬭
⬭ Serious illness or injury to a close family member	⬭	⬭	⬭
⬭ Serious illness or injury of self	⬭	⬭	⬭
⬭ Major change in financial circumstances	⬭	⬭	⬭

The above information is complete to the best of my knowledge and I have not omitted any pertinent information:

_____ _____

Patient Signature **Date**