

NOVA Orofacial Pain, TMD & Dental Sleep Medicine
5222 Rolling Rd.
Burke, VA 22015

HEAD AND NECK PAIN EVALUATION FORM

Date: _____ Name: _____

Date of Birth: _____ Age: ___ Height: ___ Weight: ___

Address: _____ City & State: _____ Zip Code: _____

Mobile: _____ Other Phone # _____ H - W (circle one)

Email: _____

Medical Insurance: _____ Dental Insurance: _____

I. Referring Doctor and other Doctors you would like to have reports sent to;

Name of Doctor	Specialty	Phone Number	Fax Number	Address

II. Understanding Your Pain

A. Describe in ***your own words*** the problem(s) you would like help with:

B. Is nausea associated with your pain? Yes ___ No ___

Is vomiting associated with your pain? Yes ___ No ___

Does your pain increase with bright lights? Yes ___ No ___

Does your pain increase with loud noises? Yes ___ No ___

Does physical activity make your pain: Better worse no change (circle one)

Do you get an aura? (flashing lights, zigzags, blindness, smells)? Yes ___ No ___ If yes describe: _____

Does your pain wake you up from sleep? Yes ___ No ___

Does your pain keep you from falling asleep? Yes ___ No ___

Do any of your family members have the same or similar pain problems? Yes ___ No ___

Do any of these occur with your pain (circle all that apply):

Eye lid drooping Redness of the eye(s) Tearing of the eye(s) Nasal stuffiness Face sweating

Do you have difficulty opening or closing your mouth? Yes ___ No ___

Do you hear clicking or popping in your jaw joints? Yes ___ No ___

C. Is your pain Continuous or Intermittent?

If your pain is intermittent how often does it occur?

- Several times a day
- Once per day
- Several times per week
- Once per week
- Less than once per week
- Never
- Other

D. How long does your pain last?

- None
- Seconds
- Minutes
- Hours
- Days
- Weeks
- Continuous

E. Circle a number below to indicate your **highest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

F. Circle a number below to indicate your **lowest** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

G. Circle a number below to indicate your **usual** pain intensity over the past week

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

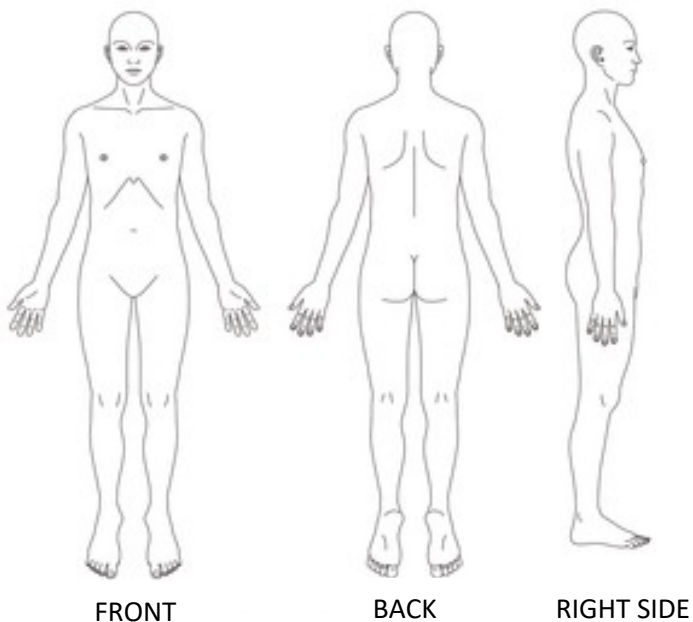
H. Below is a list of words that may describe your pain:

Please rate each word on the scale of 0-3 point scale to describe your pain.

	None	Mild	Moderate	Severe
Throbbing	0) _____	1) _____	2) _____	3) _____
Shooting	0) _____	1) _____	2) _____	3) _____
Stabbing	0) _____	1) _____	2) _____	3) _____
Sharp	0) _____	1) _____	2) _____	3) _____
Cramping	0) _____	1) _____	2) _____	3) _____
Gnawing	0) _____	1) _____	2) _____	3) _____
Hot-Burning	0) _____	1) _____	2) _____	3) _____
Aching	0) _____	1) _____	2) _____	3) _____
Heavy	0) _____	1) _____	2) _____	3) _____
Tender	0) _____	1) _____	2) _____	3) _____
Splitting	0) _____	1) _____	2) _____	3) _____
Tiring-	0) _____	1) _____	2) _____	3) _____
Exhausting	0) _____	1) _____	2) _____	3) _____
Sickening	0) _____	1) _____	2) _____	3) _____
Fearful	0) _____	1) _____	2) _____	3) _____
Punishing –	0) _____	1) _____	2) _____	3) _____
Cruel	0) _____	1) _____	2) _____	3) _____

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I. Please indicate where you have pain:



J. What makes the pain **WORSE**? Be specific.

K. What makes the pain **BETTER**? Be specific.

III. Effects of Pain

1. Circle the number of how much your pain has interfered with your activities this **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

2. Circle the number of how bothered or upset you have been about the pain in the **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

3. Circle the number to indicate how much your pain has interfered with your sleep this **past week**.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain		Moderate Pain			Severe Pain		Most Intense Pain		

IV. Current Medications

List **ALL** medicines you are **CURRENTLY** taking for medical and pain problems (including prescribed, over-the-counter, herbs, vitamins): (write on the back of this sheet if necessary)

<u>Name</u>	<u>Pill Strength</u>	<u>Number of times per day</u>	<u>Prescribing Doctor</u>	<u>Date Started</u>

Pharmacy Name and Phone# _____

V. History of Your Pain

A. When did your pain start? _____

B. When did your pain become a problem? _____

C. How many times have you gone to the emergency room for pain in the last year? _____

D. What event or events led to your present pain: Accident Other Injury
 Other Disease Cancer No Obvious Cause Surgery Other: _____

E. What do YOU think is the cause of your pain?

VI. Previous Doctors

Have you ever been evaluated at a pain center? Yes ___ No ___

If Yes list the doctors name _____

Facility Name and Address _____

List **ALL** doctors you have seen for your pain problem (continue on the back of this page if needed).

<u>Date</u>	<u>Name</u>	<u>Specialty</u>	<u>Address/Phone/Fax</u>

VII. Diagnostic Tests (MRI, CT SCANS, X-RAYS, BLOOD TESTS, ETC.):

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date Tests Results

VIII. Previous Treatments:

Indicate which of the following treatments you have tried for your problem:

- Antidepressants Acupuncture Psychotherapy Homeopathy Narcotics Chiropractor
 Biofeedback TENS Nerve Blocks Massage Relaxion Training
 Exercise Program Traction Physical Therapy Hypnosis Other (List) _____

IX. Previous Medications

Name of Medicine Dose Dates of Use Helpful? Reasons for Stopping

X. Past Medical Problems, Surgeries, Hospitalizations, and Injuries:

List any operations, hospitalizations, or injuries you have ever had.

Year Describe (reason for surgery/hospitalizations or type of injury) Hospital Doctor

XI. Allergies (if No Known Allergies check here)

List all allergies to medications and the reaction you had to any medicine (or any other allergies) :

Medicine Reaction Medicine Reaction

XII. Review of Systems

Please check if you currently have had any of the following (please indicate next to the item when the problem occurred).

A. General

- Weight Loss
 Poor Appetite
 Severe Fatigue/Low Energy
 Cancer

B. Hematologic

- Anemia
 Easy Bruising
 Bleeding Disorder
 Taking Blood Thinners

- Blood Transfusion

C. Skin

- Rash
- Nail Changes
- Bumps/Nodules

D. Head and Neck

- Headaches
- Visual Changes
- Mouth Problems
- Neck Pain
- TMJ Problems

E. Cardiac

- Exercise Limitations
- Chest Pain
- Irregular Heartbeat
- Heart Murmur
- High or Low Blood Pressure (circle one)
- Circulation Problems
- Ankle Swelling

F. Pulmonary

- Shortness of Breath
- Cough
- Asthma or Bronchitis
- Lung Disease
- Sleep Apnea
- Snoring

G. Endocrine

- Diabetes
- Thyroid Problems

H. Gastrointestinal

- Abdominal Pain
- Nausea or Vomiting (circle)
- Constipation
- Diarrhea
- History of Ulcers or Heart Burn (circle)

I. Genitourinary

- Frequent or Hesitant Urination
- Pain with Urination
- Blood in Urine
- Incontinence
- Sexual Dysfunction

J. Musculoskeletal

- Arthritis Type: _____
- Osteoporosis
- Muscle Pain
- Muscle Wasting
- Fractures Where on Body: _____

K. Neurologic

- Numbness
- Weakness
- Falling

- Stroke
- Seizures
- Memory Loss
- Loss of Balance

L. Infectious Diseases

- Measles
- Mumps
- Chicken Pox
- Rheumatic Fever
- Hepatitis Type: _____
- HIV / AIDS
- Herpes Location: _____
- Shingles
- Post-herpetic Neuralgia

M. Gynecologic

- Pregnant When: _____
- Post-Menopausal, Last Period: _____

XIII. Medical Problems: Please indicate any other medical problems that are not listed above.

XIV. Habits

- A. Smoking: Yes ___ No ___ Quit ___ Number of Packs/Day ___
- B. Alcohol Use: None ___ Occasional ___ Daily ___ How Many Drinks Per Week? ___
- C. Recreational Drugs: Current use? Yes ___ No ___
 ___ Cocaine ___ Amphetamine ___ Marijuana ___ Heroin ___ Other
- D. Coffee/Tea/Caffeine: Number of Cups/Day _____
- E. Clenching: Yes ___ No ___ Grinding Teeth: Yes ___ No ___
- F. Do you wear a night guard over your teeth? Yes ___ No ___
 If you have a night guard, is it? ___ Hard ___ Soft Is it worn on your ___ Upper ___ Lower

XV. Exercise

- A. Do you exercise? Yes ___ No ___
- B. If YES then what type of exercise? _____
- C. How many days per week do you exercise? _____

XVI. Family History

Member	Deceased or Living	Age	Medical Problems
1. Father	_____	_____	_____
2. Mother	_____	_____	_____
3. Siblings	_____	_____	_____
4. Spouse	_____	_____	_____

Are you adopted? Yes ___ No ___

XVII. Social History

A. Relationship Status:

- Single
- Significant Other
- Separated
- Divorced

B. Highest Level of Education Completed:

- GED
- College
- High school

