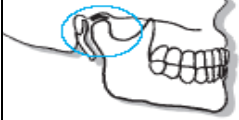




TMJ & Orofacial Pain Treatment Centers of Wisconsin



Complete this form BEFORE & bring to your appointment. If you do not, you may be rescheduled

Bring to appointment:
1. Insurance card (we will need to copy the card)
2. Picture ID (such as a drivers license), and this form

Patient information: (please print legibly in black ink – this is a legal document)

Date: _____

Last Name First Name MI Male / Female Date of Birth Age

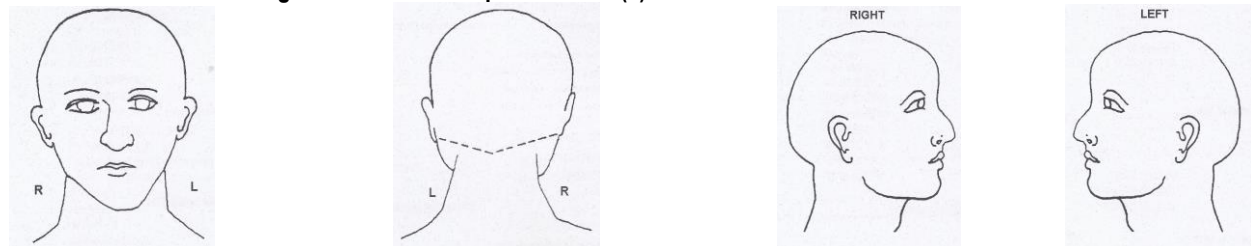
Patient Health Information:

1. Please check the following list of symptoms as applicable:

	Yes	Occasional	No		Yes	Occasional	No
Jaw and/or facial pain	()	()	()	Ear pain, fullness or ringing	()	()	()
Difficulty opening or closing jaw	()	()	()	Sore throat or difficulty swallowing	()	()	()
Clicking sound in either jaw joint	()	()	()	Dizzy or lightheaded	()	()	()
Eye pain / visual disturbances	()	()	()	Teeth pain	()	()	()
Neck pain	()	()	()				
Bite feels off	()	()	()	Your height: _____; weight: _____; Neck collar size _____			

Other condition not listed: _____

Please mark in the drawings below where the pain location(s) is located:



Do you have headaches? Y N

If yes, circle all that apply to your headaches:

- nausea
- vomiting
- light sensitivity
- sound sensitivity
- have to lie down
- miss work/school
- causes tearing

2. Sleep: How many hours per night (on average)? _____

Do you have difficulty staying asleep?	Y	N	Do you use sleeping pills?	Y	N
Do you feel frequently fatigued?	Y	N	Do you snore?	Y	N
Does someone snore disturbing your sleep?	Y	N	Do you feel refreshed in the morning?	Y	N
Told you stop breathing in sleep?	Y	N	Do you have difficulty getting to sleep?	Y	N
Are your legs restless at bedtime?	Y	N	Legs or arms restless during sleep?	Y	N

Please rate how likely you are to doze off or fall asleep in the following situations. Use the scale to rate how likely you are to fall asleep with each particular activity. **Even if you have not been in that situation lately estimate** how it would affect you.

0 - would never doze **1** - slight chance of dozing **2** - moderate chance of dozing **3** - high chance of dozing

Sitting and reading	_____	Sitting inactive in a public place (theater, meeting, library)	_____
Watching TV	_____	As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____	Sitting quietly after lunch (without alcohol)	_____
Sitting and talking to someone	_____	In a car, while stopped for a few minutes in traffic	_____
		TOTAL	_____

Have you ever had a sleep study? Y N If yes, who performed the test? (clinic / doctor) _____

When (approximately)? _____ What were the results? _____

Were you advised to use a CPAP? Y N Do you continue to use the CPAP? Y N

NAME (Last) _____ (First) _____

Please circle any of the following that apply to you, past or current:

1. General	Constitution: Weight change Loss of appetite Blurred Vision Trouble sleeping						
2. Eyes:	Visual changes Glaucoma	Blurred vision Watery eyes	Double vision Tearing	Pain	Light sensitivity	Drainage	Redness
3. Ears:	Hearing problems	Pain	Drainage	Ringing	Clicking/Popping	Dizziness	Tinnitus Vertigo
Nose:	Change in sense of smell	Congestion	Nose bleeds	Facial Pain	Nasal drainage	Sinus Pain	
Mouth & Throat:	Voice changes Difficulty swallowing	Teeth pain Jaw	Bleeding swollen gums Clicking/Popping	Change in sense of taste Dental problems	Sore throat Dentures	Laryngeal problems	
4. Skin:	Rashes	Itching/change in texture	Change in size, color, discharge of mole	Birthmarks	Change in skin, hair or nails		
5. Cardio Vascular:	Chest pain	Chest palpitations	Difficulty breathing while lying down	Swelling in legs or feet	High blood pressure	Congestive heart failure	History of Heart attack / heart disease / coronary artery disease
	Heart murmur	Valve replacement	Stent	Heart valve replacement			
6. Gastro Intestinal:	Nausea	Reflux	Loss of appetite	Difficulty swallowing	Ulcers		
7. Genitourinary:	Pregnant - Trimester	1 2 3	Birth control	Hysterectomy	Menopause	Breast feeding	
8. Respiratory:	Snoring	Sleep Apnea	Sleep Study done: date: _____	wears C-Pap:	restless leg syndrome	Bronchitis	Asthma Emphysema Pneumonia Tuberculosis
	Shortness of breath	Pain with breathing	Cough				
9. Endo:	History of diabetes	thyroid problems	Unplanned weight loss/gain	Feeling excessively cold/hot	Increase in thirst/urination	Abnormal hair growth	High Cholesterol
10. Musc/Skel:	Joint swelling/pain	Muscle aches	Cramps	Headaches	Neck pain	Rheumatoid Arthritis	Osteoarthritis Psoriatic arthritis Fibromyalgia Lyme's disease Raynaud's Disease
11. Neuro:	Problems with coordination/walking/memory/weakness		Dizziness/blackout/seizures	Tremors	Numbness or tingling	Concussion	Epilepsy Seizures Traumatic Brain Injury Headaches Slurred speech
	Stroke	Parkinsonism	Multiple sclerosis (MS)	Migraines	Traumatic brain injury (TBI)		
12. Psych:	Feeling of sadness	Difficulty sleeping	Mood changes	Unusual headache	Worry	Panic	
	Loss of appetite	Anger	Depression	Anxiety	Suicidal Thoughts	Tension	
13. Allergy:	Sneezing	Itchy/Watery eyes	Runny nose	Seasonal	Latex allergy	Food allergy	
	Medication allergy:						

NAME (Last) _____ (First) _____

Past Medical Hx:

List all current medications (prescriptions, over the counter medicine, herbs, vitamins, etc) or, attach a list of medications to this form

List medication allergies and type of reaction (i.e., rash, itching, difficulty breathing, etc.)

Surgeries & Hospitalizations:

Traumas (what type & when):

Family History:

Circle any of the following that a family member has or had (mother/father/brother/sister/grandparents)

Migraines Sleep Apnea TMJ Arthritis Cancer Diabetes Heart attack Stroke

Are you (circle one) Single Married Divorced Widowed No. of children _____

Occupation _____ How many years _____ Hobbies _____ Disabled? Y N

Health : Exercise: Do you get regular aerobic exercise? Y N If yes, how many days per week on average _____

Nutrition (describe):

Habits: Caffeine consumption? None _____; coffee ___drinks per day; soda ___drinks per day; tea ___drinks per day

Excedrin (or other pain medications with caffeine) _____pills per day

Stay awake drugs _____ Other: _____

Tobacco use, how much? None cigarettes _____ other _____

How much alcohol? None _____ drinks per day / week / month

Chewing gum use, how often? None daily weekly monthly

Stress: What is your average stress level? low / moderate / high Does stress affect your pain level? Y N

Patient's Signature

Date

Doctor's Signature

Date