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

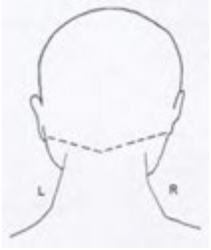
Patient Health Information:

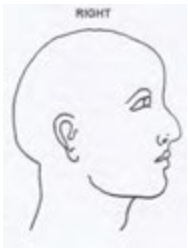
1. Please check the following list of symptoms as applicable:

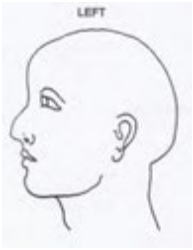
	Yes	Occasional	No		Yes	Occasional	No
Jaw and/or facial pain	( )	( )	( )	Ear pain, fullness or ringing	( )	( )	( )
Difficulty opening or closing jaw	( )	( )	( )	Sore throat or difficulty swallowing	( )	( )	( )
Clicking sound in either jaw joint	( )	( )	( )	Dizzy or lightheaded	( )	( )	( )
Eye pain / visual 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 Blurred vision Double vision Pain Light sensitivity Drainage Redness Glaucoma Watery eyes Tearing
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 Teeth pain Bleeding swollen gums Change in sense of taste Sore throat Difficulty swallowing Jaw Clicking/Popping Dental problems 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):

_____ _____ _____

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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**