Tufts University | School of Dental Medicine

Patient Name ______________________ Record Number ____________
First M.I. Last

Address: ____
Street City State Zip Code

Medical Ins. Carrier & No. ______________ Home Phone ____________

New England Medical Center Reg. No. ______________ Business Phone ____________

Date of Birth: __________ Sex ______ Ht: ____ ft. ____ in. Wt. ____ lbs

Name of Spouse: ______________ Marital Status: ______________ Occupation: ______________

Person to Call in an emergency: ______________ Phone: ______________

If you are completing this form for another person, what is your relationship to that person?

In these following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Question	Answer
1. Do you feel healthy?	_ Yes _ No
2. Has there been any change in your health within the past year?	_ Yes _ No
3. My last physical examination was on?	
4. Are you now under care of a physician?	_ Yes _ No
If so, what is the condition being treated?	
5. The name and address of my physician:	
6. Have you ever had any serious illnesses or operation or have you been hospitalized? If so, what was the illness or operation?	_ Yes _ No
7. Do you have or have you any of the following illnesses:	
a. Damaged heart valves or artificial heart valves, including heart murmur?	_ Yes _ No
b. Congenital heart lesions?	_ Yes _ No
c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary, occlusion, high blood pressure, arteriosclerosis, stroke, congestive heart failure, rheumatic heart Disease)?	_ Yes _ No
• Do you have pain in your chest upon exertion?	_ Yes _ No
• Are you ever short of breath after mild exercise?	_ Yes _ No
• Do your ankles swell?	_ Yes _ No
• Do you get short of breath when you lie down? do you need extra pillows when you sleep?	_ Yes _ No
• Do you have a cardiac pacemaker or defibrillator?	_ Yes _ No
d. Allergy?	_ Yes _ No
e. Sinus trouble?	_ Yes _ No
f. Asthma or hay fever?	_ Yes _ No
g. Hives or skin rash?	_ Yes _ No
h. Fainting spells or seizures?	_ Yes _ No
i. Diabetes?	_ Yes _ No
• Do you have to urinate (pass water) more than six times per day?	_ Yes _ No
• Are you thirsty much of the time?	_ Yes _ No
• Does your mouth frequently become dry?	_ Yes _ No
j. Thyroid dysfunction?	_ Yes _ No
k. Hepatitis, jaundice (yellow), or liver disease or cirrhosis?	_ Yes _ No
l. Arthritis?	_ Yes _ No
• Do you have a prosthetic joint replacement?	_ Yes _ No
m. Inflammatory rheumatism (painful swollen joints)?	_ Yes _ No
n. Osteoporosis?	_ Yes _ No
o. Stomach, duodenal ulcers or hiatus hernia?	_ Yes _ No

Question	Yes	No
p. Kidney trouble?	_ Yes	_ No
q. Tuberculosis?	_ Yes	_ No
r. Do you have a persistent cough or cough up blood?	_ Yes	_ No
s. Low blood pressure?	_ Yes	_ No
t. Venereal disease (sexually transmitted disease - STD)?	_ Yes	_ No
u. Epilepsy?	_ Yes	_ No
v. Psychiatric or emotional problems?	_ Yes	_ No
w. Cancer?	_ Yes	_ No
x. Immunosuppressive disorders, HIV/ AIDS?	_ Yes	_ No
8. Have you had any abnormal bleeding associated with the previous extractions, surgery, or trauma?	_ Yes	_ No
a. Do you bruise easily?	_ Yes	_ No
b. Have you ever required a blood transfusion?	_ Yes	_ No
If so, when? Why?		
9. Do you have any blood disorder such an anemia?	_ Yes	_ No
10. Have you had surgery, x-ray or drug treatment for a tumor, growth or other conditions of your head and/or neck?	_ Yes	_ No
11. Are you taking any drugs, pills, or medications, including:		
a. Antibiotics or sulfa drugs?	_ Yes	_ No
b. Anticoagulants (blood thinners)?	_ Yes	_ No
c. Medicine for high blood pressure?	_ Yes	_ No
d. Cortisone (steroid)?	_ Yes	_ No
e. Tranquilizers/ or anti-depressants/ or anti-psychotic?	_ Yes	_ No
f. Antihistamines?	_ Yes	_ No
g. Anti-asthmatics (inhalers)?	_ Yes	_ No
h. Analgesics (aspirin, ibuprofen, Motrin)?	_ Yes	_ No
i. Digitalis or drugs for heart troubles?	_ Yes	_ No
j. Nitroglycerin?	_ Yes	_ No
k. Oral contraceptive or other hormonal therapy?	_ Yes	_ No
l. Stomach or duodenal ulcer medicine?	_ Yes	_ No
m. Laxatives, diet pills?	_ Yes	_ No
n. Recreational drugs?	_ Yes	_ No
o. Vitamins, non-prescription drugs?	_ Yes	_ No
p. Herbal medications/ supplements?	_ Yes	_ No
q. Other?	_ Yes	_ No
12. Are you allergic or have you reacted adversely to:		
a. Local anesthetics?	_ Yes	_ No
b. Penicillin or other antibiotics?	_ Yes	_ No
c. Sulfa drugs?	_ Yes	_ No
d. Barbiturates, sedatives or sleeping pills?	_ Yes	_ No
e. Aspirin?	_ Yes	_ No
f. Iodine?	_ Yes	_ No
g. Codeine or other narcotics?	_ Yes	_ No
h. Other?	_ Yes	_ No
13. Have you had any serious concerns associated with any previous dental treatment? If so, explain:	_ Yes	_ No
14. Do you have any disease; condition or problem not listed above that you think we should know about? If so, explain:	_ Yes	_ No

15. Are you employed in any situation which exposes you regularly to x-rays / ionizing radiation?	_ Yes _ No
16. Are you wearing contact lenses?	_ Yes _ No
17. Do you wear any dental appliances?	_ Yes _ No
18. Are you or any members of your family in a relationship with anyone who is hurting, or threatening to hurt you or them?	_ Yes _ No
For Females only	
a. Are you pregnant?	_ Yes _ No
b. Are you nursing?	_ Yes _ No
Chief Complaint (the reason why you are coming):	
1. Date: last dental treatment: / / & last radiographs (x-rays) / /	
2. Frequency, dental visits: Frequency, cleanings:	
3. How often do you brush your teeth (#/day?)	
4. Do you use dental floss?	_ Yes _ No
5. Do you use fluoridated toothpaste?	_ Yes _ No
6. Do you use fluoride rinse?	_ Yes _ No
7. Do you use a mouth rinse or wash?	_ Yes _ No
8. Do you chew gum?	_ Yes _ No
9. Do you have or have you had any of the following:	_ Yes _ No
a. Bleeding, sore gums?	_ Yes _ No
b. Unpleasant taste/ bad breath?	_ Yes _ No
c. Burning tongue/ lips?	_ Yes _ No
d. Blisters, sores, lips, mouth?	_ Yes _ No
e. Swelling(s), lumps in mouth?	_ Yes _ No
f. Biting cheeks, lips?	_ Yes _ No
g. Sensitivity of teeth (hot, cold, sweets, biting)?	_ Yes _ No
h. Food impaction, catching?	_ Yes _ No
i. Shifting of teeth, change in bite?	_ Yes _ No
j. Gum treatment, gum or bone surgery?	_ Yes _ No
k. Dry mouth	_ Yes _ No
10. Relating to Temporomandibular Joint disorders (TMJ Disorders), do you have or have had:	
a. Difficulty and/ or pain opening your mouth, such as when yawning?	_ Yes _ No
b. Your jaw getting "stuck", "locked" or "going out?"	_ Yes _ No
c. Difficulty and/ or pain when chewing, talking or using your jaws?	_ Yes _ No
d. Noises in the jaw joints?	_ Yes _ No
e. Pain in or about the ears, temples or cheeks?	_ Yes _ No
f. Soreness of jaw muscles?	_ Yes _ No
g. Clenching or grinding of your teeth?	_ Yes _ No
h. An unusual or uncomfortable feeling bite?	_ Yes _ No
i. Frequent headaches?	_ Yes _ No
j. Recent injury to your head, neck or jaw?	_ Yes _ No
k. Treatment for jaw/ joint problem? If yes, when ?	_ Yes _ No
l. An adjustment to your bite (occlusion)?	_ Yes _ No
11. Do you drink alcohol? _ Yes _ No If so, how much per day of week?	
12. Do you use tobacco? _ Yes _ No	
If so, what type? How many days per week? How long?	
13. Do use sedatives? _ Yes _ No How many days per week? How long?	
14. How often do you consume caffeine within 2-3 hours of bedtime?	

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

School of Dental Medicine

The Craniofacial Pain, Headache and Sleep Center

Sleep Questionnaire

Have you ever had an evaluation at a Sleep Center? _ Yes _ No
If Yes, continue, otherwise go to the end of the page and sign your name:

Sleep Center Name: ______

Location: ______

Sleep Study Date: ______

The evaluation confirmed a diagnosis of: _ mild _ moderate _ severe Obstructive Sleep Apnea

The evaluation showed an RDI of ______ and an AHI of ______

CPAP Intolerance (Continuous Positive Airway Pressure device)
If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section.

I could not tolerate the CPAP device due to:

_ Mask leaks
_ I was unable to get the mask to fit properly
_ Discomfort caused by the straps and headgear
_ Disturbed or interrupted sleep caused by the presence of the device
_ Noise from the device disturbing my sleep and/or bed partner's sleep
_ CPAP restricted movements during sleep
_ CPAP does not seem to be effective
_ Pressure on the upper lip causing tooth related problems
_ A latex allergy
_ Claustrophobic associations
_ An unconscious need to remove the CPAP apparatus at night
_ Other: ______

Other Therapy Attempts: ______

What other therapies have you had for breathing disorders?
(Weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

______

Have any immediate family members been diagnosedor treated for a sleep disorder? _ Yes _ No

Sleep History
Weekdays schedule: Bed Time ______ Wake up ______

Weekends schedule: Bed Time ______ Wake up ______

I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature:	Date:
Student's printed name & signature:	Date:
Instructor's printed name & Signature:	Date:

New Medical History to be completed at least every 2 years

One Kneeland Street, 6th floor, Boston, MA 02111 | T: 617-636-6817 | F: 617-636-3831 | Web: www.orofacialpain.com

Tufts University | School of Dental Medicine

The Craniofacial Pain, Headache and Sleep Center
Health History Part II

Patient's Name: Date: Age: Sex:

Date of Birth: Home Phone: Occupation:

Chief Complaint:

Duration of the problem:

Problem most severe: ☐ Morning ☐ Afternoon ☐ Evening ☐ Sleeping ☐ Eating ☐ No pattern

SYMPTOMS					Left	Right
Face Pain	☐ Forehead	☐ Cheek	☐ Nose	☐ Around Eyes	☐	☐
Head Pain	☐ Front	☐ Back	☐ Side	☐ Top	☐	☐
Ear	☐ Pain	☐ Stuffy	☐ Ringing	☐ Loss of hearing	☐	☐
Eye	☐ Pain	☐ Redness	☐ Pressure	☐ Loss of Focus	☐	☐
Arm/Fingers	☐ Pain	☐ Tingling	☐ Numbness	☐ Weakness	☐	☐
Throat	☐ Pain	☐ Tightness	☐ Dryness	☐ Difficult to swallow	☐	☐
Jaw Joint	☐ Pain	☐ Clicking	☐ Grinding	☐ Locking open/closed	☐	☐
Upper Back	☐ Pain	☐ Stiffness	☐ Spasm	☐ Noise on movement	☐	☐
Lower Back	☐ Pain	☐ Stiffness	☐ Spasm	☐ Noise on movement	☐	☐

Dental Problem:

Bite Problem:

Other:

Pain Type: ☐ Sharp ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Dull ☐ Deep ☐ Prickling

☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe ☐ Agony

☐ Location: ☐ Localized ☐ Generalized ☐ Radiating ☐ Migrating

Duration: ☐ Intermittent ☐ Recurrent ☐ Continuous

What is your worst symptom?

What Makes it feel better?

What Makes it Feel Worse?

Family History of TMJ disorders and Pain:

Habit History: ☐ Gum Chewing ☐ Nail Biting ☐ Musical Instrument ☐ Other:

☐ Clenching ☐ Grinding

Daily Activities

Type of Exercise: Frequency:

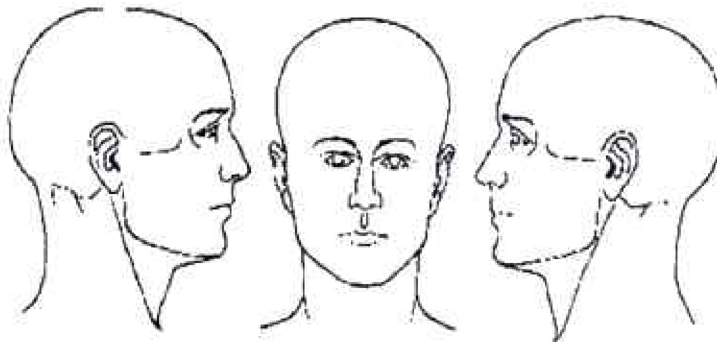
Home/Work Daily Habits:

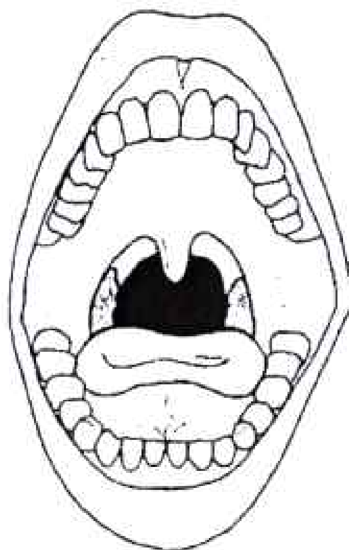
Usual Posture and position at work:

Please indicate pain areas, type and level of pain / discomfort on the diagram below as felt on your worst day.

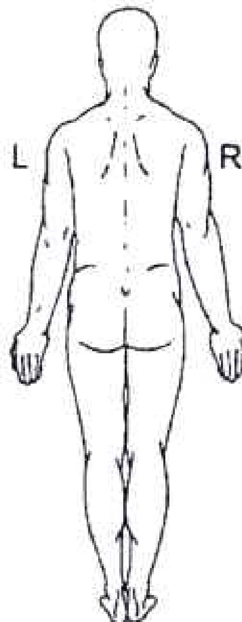
Type of Pain: B: Burning T: Throbbing S: Sharp D: Dull

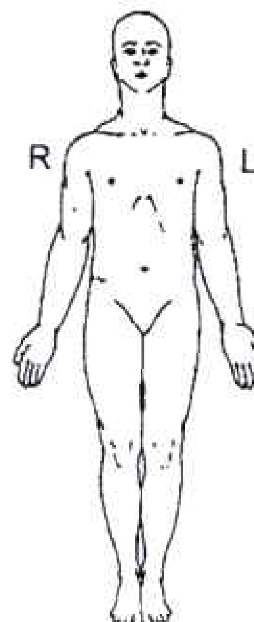
0 - 1	2 - 3	4 - 5	6 - 7	8 - 9	10
No Pain	Mild Pain	Moderate Pain	Severe Pain	Agony	Unbearable





Mouth and teeth





Medication history

Medication Status	
☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):

Medication Status	
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):
Medication Status ☐ Current ☐ Stopped ☐ As Needed	Name of Medication: Dosage: How Taken: How Long On It: Purpose of Medication: Prescribed by (doctor/Specialist Name and contact information):

Doctor Information

Who referred you to this office?
Please list previous and present health care providers.
Name: Specialty: Address: Phone: Diagnosis and Treatment:
Name: Specialty: Address: Phone: Diagnosis and Treatment:
Name: Specialty: Address: Phone: Diagnosis and Treatment:
Name: Specialty: Address: Phone: Diagnosis and Treatment:
Name: Specialty: Address: Phone: Diagnosis and Treatment:
Name: Specialty: Address: Phone: Diagnosis and Treatment:

Trauma History: In an effort to provide you with the best care possible, it is very important that we have as complete and as detailed a history of injuries you have sustained and treatments received. In addition there are certain lifestyle factors which interfere with treatment. Therefore we will be interested in aspects of your life which you may, at first glance, this unrelated to the problems which prompted your coming to the Gelb Center.

Have you been involved in accidents in the past which you head was snapped as in whiplash auto accidents? ________. If so please list every accident of this type.

____

____

____

____

Have you received a blow to the face or jaw? ______. If so please list every accident or incident of this type.

____

____

____

____

Have you been involved in any other types of accident, fall, injury requiring surgery? _______
If so please list every incident.

____

____

____

____

Please list the treatment you have received for accidents or incidents listed.

____

____

____

____

Please list previous treatments for the condition which prompted your coming to this center.

____

____

____

____

Are you presently in litigation related to head, neck, back and/or symptoms ☐Yes ☐No

If yes, please have copies of any medical records related to this injury forwarded to our center.

Nature of litigation:

____

____

____

____

Are you currently not working due to disability? ☐Yes ☐No

Partial disability ________ Total disability ________

If yes, what is the nature of your disability?

____

____

____

Date you stopped working
When has your physicians indicated that you can't return to work?

CHRONOLOGICAL HISTORY

Please give a detailed chronological history of the condition for which you have come to be examined. It is pertinent to your treatment that this portion is filled out with specific information as to the onset of your illness to present time.

FOR PATIENT'S USE	DOCTOR'S USE
(Add additional pages if needed)	