D. Kevin Hayes, D.M.D. **Sandra B. Hayes, D.M.D.**

620 East 10th Street – Cookeville, TN 38501 – (931) 526-1614

OROFACIAL PAIN QUESTIONNAIRE

Date: _____

Patient Name: _____
Last First Middle

Address: _____ Telephone No. (Home) _____
City: _____ State: _____ Zip: _____ (Office) _____

Marital Status:

_____ Married _____ Divorced _____ Separated
_____ Single _____ Cohabit _____ Widow/Widower

Number of Children: _____ Ages: _____

Are you presently employed: _____ Yes _____ No

Occupation: _____

Who referred you to our clinic? _____

Address and telephone: _____

****

1. Chief Complaint (What problem brings you to this form?)

_____

2. When did you first experience this problem? (Please describe the circumstances)

_____

_____

3. How long have you had this problem?

(Number of) _____ Years _____ Months _____ Weeks _____ Days

4. What is the usual severity of your pain? (Circle the appropriate number)

0	1	2	3	4	5	6	7	8	9	10
No pain										Extreme pain

5. Describe the way your pain feels:

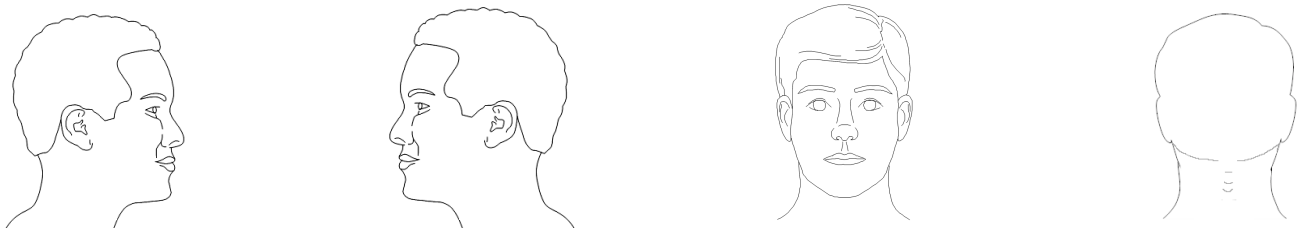
_____ Throbbing	_____ Pressure	_____ Drawing
_____ Aching	_____ Tightness	_____ Splitting
_____ Shooting	_____ Tension	_____ Tiring-exhausting
_____ Stabbing	_____ Heavy	_____ Sickening
_____ Sharp	_____ Dull	_____ Gnawing
_____ Burning	_____ Tender	_____ Cramping
		_____ Boring

6. Does the pain seem to radiate, travel, or move from the area of initial pain?

_____ Yes _____ No

_____ Pain moves up the side of the head
_____ Pain moves around to the back of the head
_____ Pain moves down the neck
_____ Pain moves into the jaw or face
_____ Other – Describe _____

7. On the diagrams below, please mark an X in the areas where you feel pain.



8. When do you have pain?

_____ Constantly
_____ Frequently but not predictably
_____ Frequently and predictably
_____ Occasionally
_____ No real pattern

9. How long does the pain last?

_____ Less than 1 minute	_____ 6-12 hours
_____ 1-10 minutes	_____ 13-24 hours
_____ Less than 1 hour	_____ Several days
_____ 1-5 hours	_____ Constant

10. Do you have numbness or unusual feelings or sensations in your face or jaw?

_____ No _____ Yes If yes, describe: _____

11. Which of the following causes or aggravates the pain?

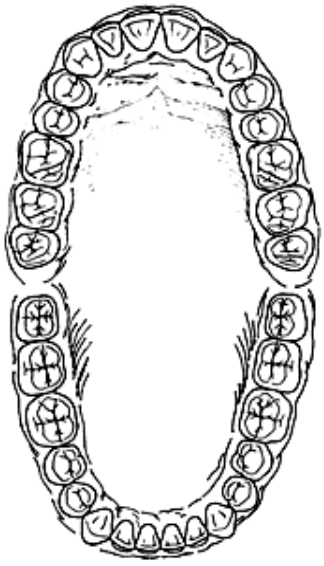
_____ Chewing
_____ Opening mouth wide
_____ Talking
_____ Playing a musical instrument
_____ Yawning
_____ Laughing
_____ Singing
_____ Eating certain foods
_____ Hot or cold foods/drinks
_____ Damp or cold weather
_____ Lack of sleep
_____ Stress or emotional upset
_____ Riding in a car for long periods
_____ Sitting for long periods
_____ Exercise
_____ Other: _____

12. Which of the following relieves the pain?

_____ Massage of the area
_____ Warm soaks or compresses
_____ Hold jaw in certain positions
_____ Pain medication
_____ Moving or manipulating
_____ Heat
_____ Other: _____
_____ Exercise
_____ Ice or cold compresses
_____ Sleep
_____ Time
_____ Relaxation
_____ Nothing helps

13. Do you have any teeth that hurt or ache?

_____ No _____ Yes If yes, please circle which one(s) on diagram



14. Do you have any painful areas in or around your mouth?

_____ No _____ Yes If yes, please describe: _____

15. Do you have pain in your jaw or face?

_____ No _____ Yes If yes, which side? _____ Right _____ Left

16. Do you have problems with your ears?

_____ No _____ Yes If yes, which side? _____ Right _____ Left

If yes, which of the following:

_____ pain _____ buzzing _____ ringing _____ stuffiness

Other: _____

17. Are you bothered by dizziness or dizzy spells?

_____ Yes _____ No

18. Do you have pain in the temple or above the ear?

_____ Yes _____ No

19. Do you wake up with a headache? _____ Yes _____ No

20. Do you have headaches later in the day? _____ Yes _____ No

21. Do you have headaches as often as once per week? _____ Yes _____ No

If yes, how many per week? _____

22. Is there any nausea or vomiting associated with your headaches? _____ Yes _____ No

23. Are there vision changes associated with your headaches? _____ Yes _____ No

If yes, what kind? _____

24. Do you take any medication for the headache pain? _____ Yes _____ No

If yes, what? _____

25. What relieves the headache?

_____ Pain medication _____ Rest _____ Nothing
_____ Sleep _____ Exercise Other: _____

26. Do you have pain in your neck? _____ Yes _____ No

27. Do you have pain in the back of your head? _____ Yes _____ No

28. Do you have pain in your back? _____ Yes _____ No

Which side? _____ Right _____ Left _____ Both _____ Middle

29. Do you have pain, numbness, or tingling in your arms, hands or fingers?

_____ Yes _____ No

30. Do you feel stiff or sore when you get up in the morning? _____ Yes _____ No

31. Do you have aches and pains all over your body? _____ Yes _____ No

32. Do you tire or fatigue easily? _____Yes _____ No

33. Have you ever been in an accident or received a "blow" or injury to any part of your face, head, neck, or back?

_____ Yes _____ No If yes, when?_____

Describe the circumstances _____

34. Are you aware of your jaw making sounds? _____ Yes _____ No If yes, please answer the

following: Which side? _____ Right _____ Left _____ Both sides

Describe the nature of the sound:

_____ clicking
_____ grating
_____ popping
_____ cracking

Other _____

When do you notice the sound?

_____ early opening
_____ middle opening
_____ wide opening
_____ moving jaw side to side
_____ chewing
_____ while closing

Is the sound always present? _____ Yes _____ No

Does the sound seem to be caused by the pain? _____ Yes _____ No _____ Sometimes

35. Has your jaw ever locked open before? _____ Yes _____ No

Which side? _____ Right _____ Left _____ Both sides

Date of first occurrence _____

If so, are you able to replace the jaw to normal position yourself? _____ Yes _____ No

36. Has your jaw ever locked closed or partially closed? _____ Yes _____ No

_____ Right side _____ Left side _____ Both sides

37. How many times has your jaw locked open or closed during the past year? _____

38. Do you have pain when your jaw locks open or closed? _____ Yes _____ No

39. Have you noticed any decrease in how far you can open your mouth? _____ Yes _____ No

40. When you open your mouth, does something in your jaw joint feel like it is in the way?

_____ Yes _____ No

Which side? _____ Right _____ Left _____ Both sides

41. Do you need to move your jaw from side to side or forward to enable you to open or close your mouth?

_____ Yes _____ No

Which side? _____ Right _____ Left _____ Both

42. Have you ever had braces on your teeth? _____ Yes _____ No

If yes, when? _____

43. Do you chew gum? _____ Yes _____ No

If yes, how much?

_____ 0 – 25% of waking hours
_____ 25–50% of waking hours
_____ 50 – 75% of waking hours
_____ 75– 100% of waking hours

44. Have you noticed any other oral habits or practices that aggravate or cause pain? (chewing ice, chewing finger nails, biting pencils, etc.)

_____ Yes _____ No If yes, what?_____

45. Do you clench or grind your teeth? _____ Yes _____ No

46. Do you feel that clenching or grinding your teeth causes or contributes to your pain?

_____ Yes _____ No _____ Sometimes

47. Do you feel that you are under stress much of the time?

_____ Yes _____ No _____ Occasionally

48. Does increased stress seem to make the pain problem worse?

_____ Yes _____ No _____ Occasionally

49. Do you get any type of regular exercise? _____ Yes _____ No;

If yes, what kind? _____

50. Do you enjoy your job? _____ Yes _____ No

51. Do you feel that you usually eat a healthful, balanced diet? _____ Yes _____ No

52. For each of the beverages listed below, write in the average number you drink each day:

Natural coffee _____ cups/day
Decaffeinated coffee _____ cups/day
Tea _____ cups/day
Carbonated soft drinks _____ cans or bottles/day

53. Does your pain prevent you from performing your normal daily activities?

_____ Yes _____ No

54. Do you have times when you feel as though you can't breathe in enough air?

_____ Yes _____ No If yes, please explain _____

55. Do you notice that you hands and feet are often cold or hard to keep warm?

_____ Yes _____ No

56. Has your interest in sexual activities decreased since you have been experiencing pain?

_____ Yes _____ No

57. Do you feel sad or depressed much of the time? _____ Yes _____ No

58. Have you experienced any of the following:

_____ divorced
_____ moving
_____ re-marriage
_____ serious illness of a friend or loved one
_____ death of a friend or loved one
_____ job dissatisfaction
_____ being fired
_____ job change
_____ separation from spouse
_____ abuse, physical or sexual
_____ problems with children
_____ chemical dependency
_____ other; please explain_____
_____

59. Are you presently, or have you ever been under the care of a psychiatrist or a psychologist?

_____ Yes _____ No

If yes, for what condition and when? _____

60. Do you sleep well _____ Yes _____ No

61. Do you awaken frequently during the night? _____ Yes _____ No

62. Are you a restless sleeper? _____ Yes _____ No

63. Do you have vivid dreams or nightmares? _____ Yes _____ No

64. Do you go to bed more tired than your daily activities justify? _____ Yes _____ No

65. Do you feel rested when you get up in the morning? _____ Yes _____ No

66. What types of health care providers have you seen for your problem?

_____ none
_____ general dentist
_____ dental specialist; type _____
_____ family physician
_____ ENT physician
_____ neurologist; neurosurgeon
_____ orthopedic surgeon
_____ rheumatologist
_____ rehabilitation medicine; physical medicine
_____ pain clinic
_____ osteopathic physician
_____ chiropractor
_____ physical therapist
_____ other; describe _____
_____

67. Please list the names of the above health care providers:

_____

_____

_____

_____

68. Please describe the treatment which you have received for your pain:

_____

_____

_____

_____