LOMA LINDA UNIVERSITY
School of Dentistry

CENTER FOR DENTISTRY
Faculty Dental Practices

CHART # _____

Orofacial Pain Management

PATIENT DATA

NAME: PLEASE PRINT	LAST	FIRST	MI	DATE OF BIRTH	AGE	SEX	S.S.#

MAILING ADDRESS	STREET OR BOX #	CITY	STATE	ZIP

AVAILABLE FOR TREATMENT (PLEASE CHECK)

	MON	TUES	WED	THURS	FRI	ANY-TIME
AM						
PM						

OCCUPATION | WORK PHONE | HOME PHONE

MARITAL STATUS: S ☐ M ☐ D ☐ W ☐

MILITARY DEPENDENT: ☐

BEST TIME TO CALL

PLAN FOR PAYMENT

☐ CASH/CHECK
☐ CHARGE CARD ☐ Insurance _____
☐ LLU/LLUMC Employee

Major dental problem or reason for coming to the TMJ Clinic _____

CONSENT

Permission is granted to students, staff, and faculty to perform procedures, including the giving of anesthetics or taking of photographs which may be necessary for my dental treatment or for teaching purposes. I have the right to refuse any procedure. I will be responsible if I terminate treatment against dental advise.

Date _____ Signature of Patient, Parent/Guardian _____

	YES	NO
1. Have you had an unexplained gain or loss of weight (past 6 months)? How much? _____	☐	☐
2. Do you smoke or use tobacco? If Yes, how much? _____	☐	☐
3. Do you drink alcoholic beverages? If Yes, how much? _____	☐	☐
4. Have you ever been treated for cancer?	☐	☐
5. Have you ever had radiation treatment?	☐	☐
6. Do you have a poor appetite?	☐	☐
7. Do you sleep poorly or use medications to sleep?	☐	☐
8. Do you feel that you are currently more tired than usual?	☐	☐
9. Do you have many body aches and pains?	☐	☐
10. Do you have night sweats or recurring fever?	☐	☐
11. Have you ever used intravenous drugs?	☐	☐
12. Have you used cocaine or "crack" within the past 6 months?	☐	☐
13. Do you actively engage in high risk behavior for infectious diseases (e.g., AIDS, hepatitis)?	☐	☐
14. Please describe your general health _____		

Do you have or have you ever had:

HEAD AND NECK	YES	NO
15. Recurrent headaches	☐	☐
16. Glaucoma / eye disease	☐	☐
17. Recurrent earaches/hearing problems/ringing	☐	☐
18. Chronic sinusitis / post nasal discharge	☐	☐
19. Recent difficulty swallowing	☐	☐
20. Persistent sore throat and hoarseness	☐	☐
21. Swollen neck glands	☐	☐
22. Recurrent neckache or neck pain	☐	☐
23. Injury to head, neck, jaw, teeth	☐	☐

DENTAL	YES	NO
24. Chronic face pain/jaw pain	☐	☐
25. Clicking/popping jaw	☐	☐
26. Difficulty opening or closing jaw	☐	☐
27. Unable to chew food well	☐	☐
28. Blisters/sores on lips or mouth	☐	☐
29. Unpleasant taste/bad breath	☐	☐
30. Burning tongue/lips	☐	☐
31. Swelling/lumps in mouth	☐	☐
32. Bleeding or infected gums	☐	☐
33. Loose teeth	☐	☐
34. Pain when chewing or opening mouth	☐	☐
35. Bothersome catching of food between teeth	☐	☐
36. Recent toothache/sensitivity	☐	☐
37. Uncomfortable bite	☐	☐
38. Recent need to chew on one side	☐	☐
39. Clenching/grinding	☐	☐
40. Your bite adjusted	☐	☐
41. Bite appliance (TMJ splint)	☐	☐
42. Gum treatment or surgery	☐	☐
43. Orthodontic treatment (Braces)	☐	☐

Do you have or have you ever had:

NEUROMUSCULAR SYSTEM	YES	NO
44. Fainting spells or loss of consciousness	☐	☐
45. Seizures	☐	☐
46. Numbness, tingling, or paralysis	☐	☐
47. Muscle weakness/multiple sclerosis	☐	☐
48. Recurrent backaches	☐	☐
49. Problem/walking, balance, dizziness	☐	☐
50. Persistent stiffness or painful joints	☐	☐
51. Artificial bone or joint implants	☐	☐
52. Recent or unusual headache	☐	☐

RESPIRATORY	YES	NO
53. Breathing problems	☐	☐
54. Asthma or emphysema	☐	☐
55. Tuberculosis or a persistent cough	☐	☐
56. Coughed up blood	☐	☐
57. Pneumonia	☐	☐

CARDIOVASCULAR	YES	NO
58. High blood pressure	☐	☐
59. Awaken with breathing difficulty	☐	☐
60. Difficulty breathing when lying down	☐	☐
61. Swollen ankles	☐	☐
62. Irregular or rapid heart beats	☐	☐
63. Chest pain due to physical exertion	☐	☐
64. Chest pain when upset	☐	☐
65. Rheumatic heart disease or fever	☐	☐
66. Congenital heart disease/heart murmur	☐	☐
67. Prolapsed heart valve	☐	☐
68. Cardiac or vascular surgery	☐	☐
69. Heart attack and/or angina	☐	☐
70. Other heart problem	☐	☐
71. A stroke	☐	☐

DENTAL CENTER

HEALTH QUESTIONNAIRE

Do you have or have you ever had:

GASTROINTESTINAL/GENITO-URINARY	YES	NO
72. Persistent diarrhea/odd colored stools	☐	☐
73. Colitis or ulcers	☐	☐
74. Unexplained vomiting/frequent nausea	☐	☐
75. Alcoholic liver disease	☐	☐
76. Hepatitis or other liver disease	☐	☐
77. Jaundice (yellow skin or eyes)	☐	☐
78. Awaken more than twice a night to urinate	☐	☐
79. Kidney disease/renal dialysis	☐	☐
80. A kidney transplant	☐	☐
81. Any urinary infection	☐	☐
82. Syphilis	☐	☐
83. Gonorrhea	☐	☐
84. Any other sexually transmitted disease	☐	☐

Have you been allergic to or had a bad reaction to:

ALLERGIES	YES	NO
85. Penicillin	☐	☐
86. Sulfa drugs	☐	☐
87. Dental anesthetics	☐	☐
88. Narcotics	☐	☐
89. Dairy Products	☐	☐
90. Other (Specify) _____	☐	☐

Do you have or have you ever had:

HEMA/ENDO/IMMUNE	YES	NO
91. Bruise easily/bleed excessively after a cut	☐	☐
92. A blood transfusion	☐	☐
93. Anemia or denied permission to give blood	☐	☐
94. Diabetes or been frequently thirsty	☐	☐
95. Thyroid or adrenal gland disease	☐	☐
96. Leukemia (cancer of the blood)	☐	☐
97. AIDS or ARC (AIDS Related Complex)	☐	☐
98. Positive blood test for HIV antibodies	☐	☐
99. Skin blotches or rash	☐	☐
100. Rheumatoid arthritis	☐	☐
101. Chronic itching	☐	☐

WOMEN ONLY	YES	NO
102. Do you menstruate regularly?	☐	☐
103. Do you flow heavily?	☐	☐
104. Are you now pregnant?	☐	☐
105. If so, please give due date _____	☐	☐
106. Are you in or have you passed through menopause (change of life)?	☐	☐
107. Are you taking hormones?	☐	☐
108. Are you taking birth control pills?	☐	☐

Has anyone in your family (grandparent, parent, sibling, child) ever had:

FAMILY HISTORY	YES	NO
109. Bleeding disorder	☐	☐
110. Heart disease	☐	☐
111. Mental/emotional disorders	☐	☐
113. Cancer	☐	☐
114. Tuberculosis	☐	☐
115. Diabetes	☐	☐

112. Any genetic diseases/illnesses (please specify) _____

BEHAVIORAL	YES	NO
116. Are you available and able to sit for a three-hour appointment?	☐	☐
117. Are there some aspects of the appearance of your teeth and jaw that need to be changed?	☐	☐
118. Do you often feel depressed or moody?	☐	☐
119. Do you often feel anxious or nervous?	☐	☐
120. Have you ever had psychiatric or psychological counseling?	☐	☐
121. Did you ever avoid a dental appointment because you were frightened?	☐	☐
122. Do you ever feel uncomfortable asking questions of doctors?	☐	☐

List all prescription and non-prescription drugs (Including aspirin) taken within the past 6 months:

Name	Dosage	Name	Dosage	Name	Dosage
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

Please list all hospitalizations and emergency room visits (include dates and reasons):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my dentist at my next appointment.

Patient Signature: _____ Date: _____ (mo/day/yr)

Guardian: _____ Date: _____ (mo/day/yr)

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DATE: _____

REGISTRATION

Who referred you to the Pain Management?

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

Please provide us with the names and complete addresses of your doctors.

DENTIST

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

PHYSICIAN

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

If you have other health care practitioners who are actively involved in your treatment, please provide us with their names and addresses.

SPECIALTY

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

SPECIALTY

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

PLEASE CONTINUE ON BACK IF NECESSARY

SPECIALTY

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____

SPECIALTY

Name _____

Address _____

City _____ State _____ Zip _____

Phone Number (_____) _____