**Orofacial Pain Center**
Naval Postgraduate Dental School
Navy Medicine Professional
Development Center
8955 Wood Rd
Bethesda, MD 20889-5628

Com (301) 295-1495
DSN 295-1495
FAX (301) 295-2070

# Orofacial Pain Examination Form

**May 2021**

***Please complete pages 1-11 and select choices whenever available.***

Exam Date _____

Name _____

DoD ID _____ DOB _____ Gender: ○M ○F

Duty Status Select Status Age_____ Ethnicity_____

Branch of Service Select Branch Rank / Rate _____

Phone (H) _____ (W) _____ (Cell) _____

Address _____

City _____ State _____ Zip _____

Email _____

The clinic who referred you for this evaluation? _____

Is this evaluation for one of the following:

○ Medical/Physical Evaluation Board ○ Second Opinion ○ Litigation/Legal Issue

Tele-medicine info:
With the current COVID climate we are offering various tele-medicine options for our initial encounter to review your medical history and Orofacial Pain Intake Questionnaire. We usually spend about 30-40 minutes on this portion of the exam. Please indicate your preferred virtual platform and user ID among the following DOD approved methods:

○MS Teams ○Skype ○Google Duo ○FaceTime

User ID:_____

Reset Form

Why are you here? Describe your pain or problem(s):

_____

_____

_____

When and how did your pain /problem(s) start? _____

_____

_____

Who have you seen for your pain /problem(s)? Please circle**:** Dentist, Primary Care Provider, Neurology, ENT, Pain Clinic, Physical Therapy, Chiropractor, Other _____

_____

_____

What treatments and//or medications have you received for you pain problem(s)?

_____

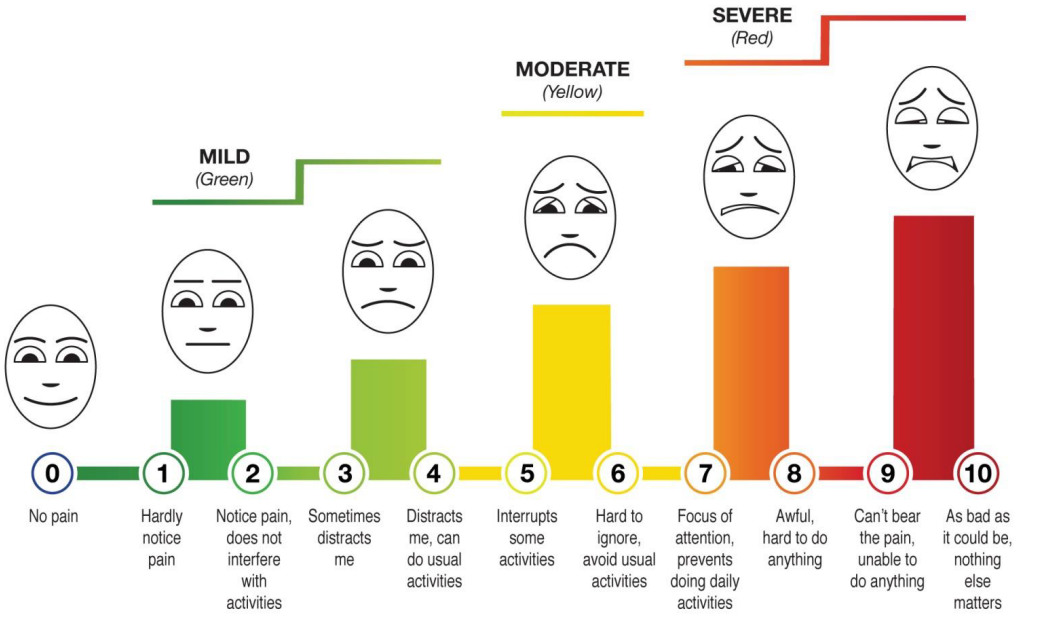
_____

**Select the word(s) that describe your pain or problem(s)? Write-in:**

| Sharp | Burning | Electric-like | Aching | Throbbing | Dull | Pulsing | Pressing | Stabbing | Tingling |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**What is your level of pain from <u>the painful area that is the main reason for your visit</u>?**

**Please mark your pain level on the following page based on the chart below.**



| | No discomfort | | | | | | | | | | Worst pain imaginable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Today | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |
| 2. At its Worst | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |
| 3. On Average | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |

Any pain free days? ○ Yes ○ No When were you last completely pain free? _____

**Please Rate Your Pain Interference**

4. In the past 6 months, how much has your pain interfered with your daily activities?

| No Interference | | | | | | | | | | Unable to perform any activities |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 0 | | | | | 5 | | | | | 10 |

5. About how many days, in the last six months, have you been kept from your usual activities (work, school and/or housework) because of your pain? _____

What does your pain limit you from doing?

_____

_____

_____

**Pain Modifiers:**

What starts your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

Does anything else happen when your pain is present (swelling, change in vision, nausea, etc.)? _____

_____

What do you think is wrong or causing your pain/problem (s) and what do you think needs to be done about it?

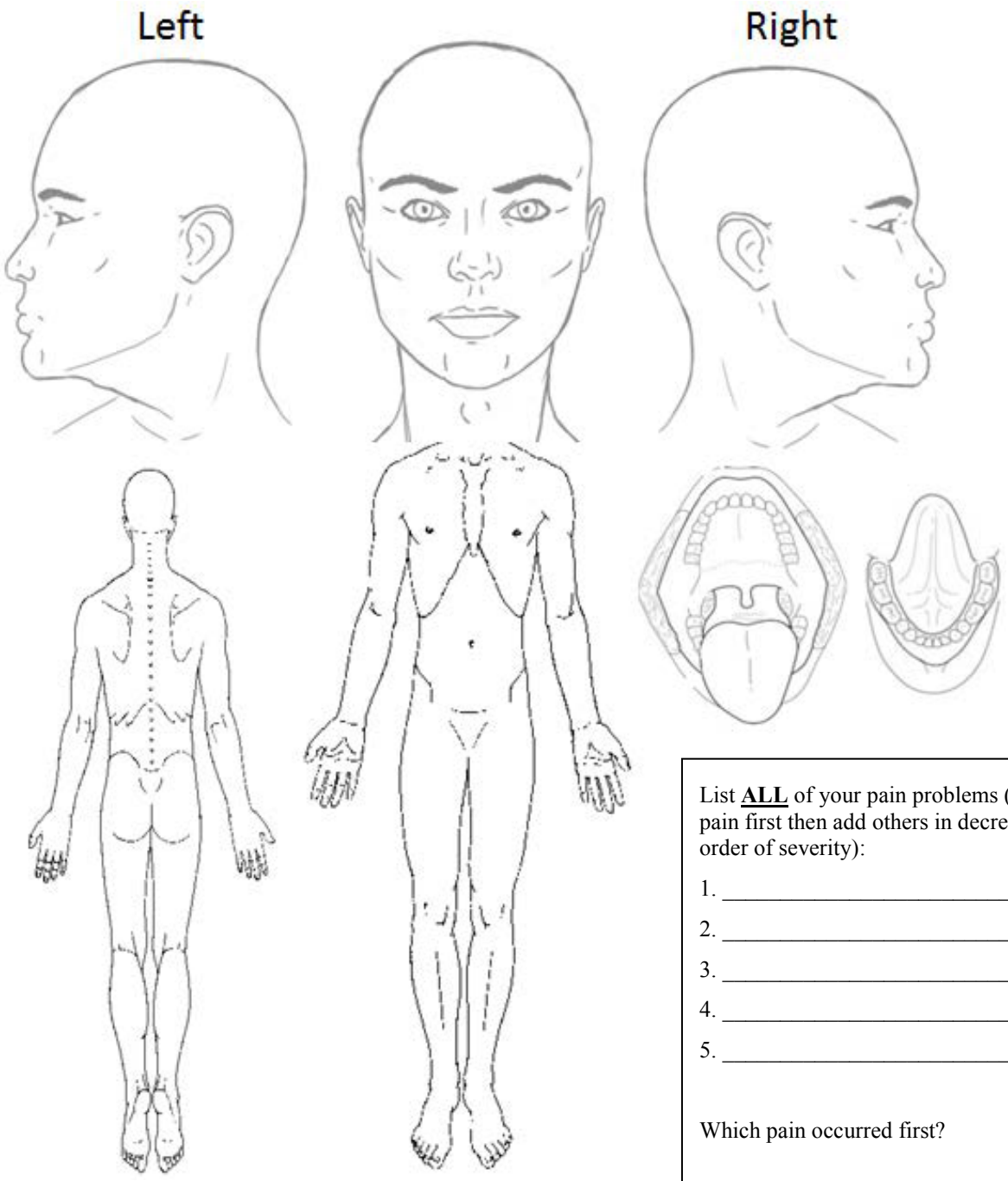
_____

_____

Why did you decide to seek care at this time? _____

_____

Outline/draw/highlight the location(s) of **ANY AND ALL BODY PAIN** that you are experiencing.




List **ALL** of your pain problems (worst pain first then add others in decreasing order of severity):

1. _____
2. _____
3. _____
4. _____
5. _____

Which pain occurred first?

_____

**What is your overall level of total body pain?**

Please mark your levels of overall body pain on the lines below.

| | No discomfort | | | | | | | | | | Worst pain imaginable |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Today | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |
| 2. At its Worst | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |
| 3. On Average | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |

Any pain free days? ○Yes ○No When were you last completely pain free? _____

**Medical History**

Medical Conditions: _____

_____

Allergies: _____

History of hospitalization? _____

_____

History of injury or trauma? ◯Yes ◯No

_____

Have you ever had a traumatic brain injury (TBI) or a concussion? ◯Yes ◯No

If yes, when? _____ how did it occur?_____

If yes, did it happen on a military deployment? ◯Yes ◯No

Current prescription medications: _____

_____

Current non-prescription medications: _____

Herbal/Dietary supplements and Vitamins: _____

History of family medical conditions (parents, siblings, etc.)? _____

**Personal Information**

Nicotine ◯Y ◯N How long? _____ cigarettes _____/day cigars/pipe _____ snuff _____ vape_____

Alcohol ◯Y ◯N beers / ◯day ◯week | wine / ◯day ◯week | liquor / ◯day ◯week

Caffeine ◯Y ◯N cups(cans)/day _____ ☐coffee ☐tea ☐soda ☐energy drinks ☐supplements

Water ◯Y ◯N _____ ◯glasses ◯bottles ◯oz/day

Do you skip any meals? ◯Yes ◯No Which? ☐Breakfast ☐Lunch ☐Dinner

Weight: ____ lbs Height: ____ft___inches Neck size:____inches Any recent weight gain/loss? ◯Yes ◯No

Exercise level: ◯None ◯Slight ◯Moderate ◯Active Any activity limitations? ◯Yes ◯No

Please estimate how many hours a day (0 to 24 hours) that your teeth touch in any contact. _____

Do you clench or grind your teeth? ◯Yes ◯No ◯Don't know

If yes, how do you know? ☐self-aware ☐told by dentist ☐told by others

Do you? ☐bite your nails ☐chew gum ☐protrude tongue ☐hold the tongue to the roof of the mouth
other habits: _____

**Please rate your levels of:**

| | None | | | | | | | | | | Worst possible |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Stress | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |
| Anger | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | 0 | | | | | 5 | | | | | 10 |

**Personal/Family History**

Occupation: _____

Marital status: ○Single ○Married ○Separated ○Divorced

Children: ○Y ○N If yes, list ages _____

Are there any special needs or circumstances involving you, your family members or your job? ○Yes ○No

_____

_____

Do you have any history of the following or similarly threatening, stressful or frightening life events? ○Yes ○No

Abuse - at any age (physical, emotional or sexual), childhood neglect, physical or sexual assault, motor vehicle accident, deployment to a conflict zone, panic attacks, near drowning, other _____

_____

_____

_____

Have you been told that you have post-traumatic stress symptoms (PTSS) or post-traumatic stress disorder (PTSD)?

○Yes ○No If yes, when?_____

**Headaches**

Do you have problems with headaches? ○Yes ○No For how long? _____

Any family history of headaches? ○Yes ○No

Do you have more than one kind of headache? ○Yes ○No If yes, how many kinds?_____

Please describe each type of headache you experience.

| | #1 | #2 | #3 |
|---|---|---|---|
| Where on your head does the headache occur? | | | |
| Average pain level 0 (no pain) to 10 (worst ever) | | | |
| How often do they occur? (daily, weekly, monthly) | | | |
| When do they occur? (morning, evening, etc.) | | | |
| How long do they last? (secs, mins, hours, days) | | | |
| What starts (triggers) your headache? | | | |

With your headache, do you experience?

☐nausea ☐vomiting ☐light sensitivity ☐sound sensitivity ☐dizziness ☐aura (altered sensations) ☐other _____

**Do you experience any of the following?**

Neck pain? ◯Yes ◯No _____ Neck sounds? ◯Yes ◯No_____

If yes, when did it start? _____ When is it the worst? _____

Pain from areas below your shoulders? ◯Yes ◯No If yes, where? _____

Dizziness or lightheadedness? ◯Yes ◯No _____

Ear problems? ◯Yes ◯No ☐fullness ☐stuffiness ☐ringing ☐sounds ☐pain ☐other _____

Numbness or tingling? ◯Yes ◯No ☐around mouth ☐head/face ☐arms/fingers ☐legs/toes
other_____

Jaw pain? ◯Yes ◯No _____

Tooth pain? ◯Yes ◯No _____

Changes in the way your teeth fit together? ◯Yes ◯No _____

Altered jaw movement(s)? ◯Yes ◯No _____

Jaw joint (TMJ) sounds? ◯Yes ◯No If yes, is it? ☐popping ☐clicking ☐grating/grinding
other _____

Did jaw joint (TMJ) sounds begin before your pain started? ◯Yes ◯No ◯unsure

Have there been any changes in the jaw sounds? _____

If you have jaw pain or stiffness, when is it the worst? ☐awakening ☐morning ☐noon ☐afternoon ☐evening

Does your jaw problem affect your ability to eat? ◯Yes ◯No _____

**Sleep History**

How many hours do you sleep? Average night _____Good night _____ Bad night _____

How long does it take to fall asleep? Average night _____Good night _____ Bad night _____

Do you have a regular/consistent sleep schedule? ◯Yes ◯No _____

Do you snore, gasp or have a history of sleep apnea? ◯Yes ◯No _____

Do you sleep using a CPAP &/or an oral device for sleep apnea? ◯Yes ◯No _____

Is your obstructive sleep apnea ◯mild ◯moderate ◯severe

What position do you fall asleep in? ☐side ☐back ☐stomach

Do you have problems with nightmares? ◯Yes ◯No If yes, are they recurring? ◯Yes ◯No

What are the words that best describe your sleep? ☐Good ☐Fair ☐Poor ☐Sound ☐Light ☐Restless

What percentage of the time is your sleep quality restorative? (0 - 100%)_____

**Please list any additional information that you feel is important for us to know about you, your pain complaint or other aspects of your visit.**

_____

_____

_____

_____

_____

_____

Please continue and complete the questionnaires on the following pages

Over the last two weeks, how often have you been bothered by the following problems?

| | Not at all | Several Days | Over Half the Days | Nearly Every Day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Not being able to stop or control worrying | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Worrying too much about different things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble relaxing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Being so restless that it's hard to sit still | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Becoming easily annoyed or irritable | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling afraid as if something awful might happen | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Little interest or pleasure in doing things | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling down, depressed, or hopeless | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble falling or staying asleep, or sleeping too much | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling tired or having little energy | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Poor appetite or overeating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 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 |
| Thoughts that you would be better off dead, or of hurting yourself in some way | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

How difficult have these symptoms 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

**For each question, please *CIRCLE* the number that best describes your answer.**

1. Please rate the *CURRENT (i.e. LAST 2 WEEKS) SEVERITY* of your insomnia problem(s).

| Insomnia problem | None | Mild | Moderate | Severe | Very severe |
|---|---|---|---|---|---|
| a. Difficulty falling asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| b. Difficulty staying asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| c. Problem waking up too early | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

2. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

| Very Satisfied | Satisfied | Moderately Satisfied | Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

3. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

| Not at all | Barely | Somewhat | Much | Very Much |
|---|---|---|---|---|
| ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

4. How WORRIED/DISTRESSED are you about your current sleep problem?

| Not at all | Barely | Somewhat | Much | Very Much |
|---|---|---|---|---|
| ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

5. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.)?

| Not at all | A Little | Somewhat | Much | Very Much |
|---|---|---|---|---|
| ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

**Instructions:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

| Event | Happened to me | Witnessed it | Learned about it | Part of my job | Not sure | Doesn't apply |
|---|---|---|---|---|---|---|
| 1. Natural disaster (for example, flood, hurricane, tornado, earthquake) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Fire or explosion | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Serious accident at work, home, or during recreational activity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Exposure to toxic substance (for example, dangerous chemicals, radiation) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Other unwanted or uncomfortable sexual experience | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Combat or exposure to a war-zone (in the military or as a civilian) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Life-threatening illness or injury | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Severe human suffering | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Sudden violent death (for example, homicide, suicide) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Sudden accidental death | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Serious injury, harm, or death you caused to someone else | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Any other very stressful event or experience | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

| In the past month, how much were you bothered by: | Not at all | A little bit | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 4. Feeling very upset when something reminded you of the stressful experience? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 8. Trouble remembering important parts of the stressful experience? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 10. Blaming yourself or someone else for the stressful experience or what happened after it? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 12. Loss of interest in activities that you used to enjoy? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 13. Feeling distant or cut off from other people? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 16. Taking too many risks or doing things that could cause you harm? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 17. Being “superalert” or watchful or on guard? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 18. Feeling jumpy or easily startled? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 19. Having difficulty concentrating? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| 20. Trouble falling or staying asleep? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |