MEDICAL & DENTAL HISTORY *CONFIDENTIAL*

Last Name:	Title:
First Names:	DOB:
Who recommended this practice to you? ☐ Facebook ☐ Google ☐ Newspaper ☐ Dr ___________ ☐ Friend ☐ Website ☐ Sign ☐ Yellow pages ☐ Other	
Residential Address:	
Suburb:	Postcode:
Mailing Address:	
Suburb:	Postcode:
Home Phone:	Mobile Phone:
Email:	Work Phone:
Person responsible for paying the fees:	Health fund ☐ Yes ☐ No (Specify)
Emergency Contact (Name):	Emergency Contact (Number):
The name of your Physician (GP)? Or medical practice	
Are you currently under medical care? ☐Yes ☐ No If yes, for what reason?	
Do you have a specific reason for attending today? ☐ toothache ☐broken teeth ☐ missing teeth ☐ facial/jaw/ear pain ☐ braces ☐ clean ☐check up ☐ headaches ☐ worn teeth ☐ implants ☐appearance of teeth ☐bite issues ☐sleep issues ☐other	

On a scale of 1-5, how nervous would you say you are at the dentist?

Completely at ease	1	2	3	4	5	Very Nervous

Chief complaint:

☐ I release and give my permission for this office to request information and communicate with other providers. I prefer my documents to be ☐ Emailed ☐ Posted ☐ Faxed	
Patient Signature:	Date:

Disclaimer for Research Purposes: *Dr Karen McCloy has active research interests in both sleep disorders and facial pain. Your records may be de-identified and used for research purposes at some time.*

☐ *Please indicate by ticking the box if you do NOT consent for your records to be used*

CURRENT MEDICATIONS

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs etc.

Medication	Dosage	Reason for taking	Time of day
☐ See attached list * If you require another page for your medication, please ask reception			

PREVIOUS TREATMENTS / MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment &/or Medication	Doctor / Provider Name	Approximate Date & Duration of treatment	Success of treatment

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Please tick any of the conditions below that you have or have had

CARDIOVASCULAR		HAEMATOLOGIC		NEUROLOGIC	
Heart attack	☐	Blood transfusion	☐	Vision problems	☐
High blood pressure	☐	Anaemia	☐	Glaucoma	☐
Heart murmur	☐	Haemophilia	☐	Earache, ringing in the ear	☐
Heart surgery	☐	Tendency to bleed longer than normal	☐	Hearing loss	☐
Heart valve disease	☐	Leukaemia	☐	Migraines	☐
Rheumatic fever	☐	Fluid retention	☐	Fainting or dizzy spells	☐
Congenital heart defect	☐	HIV	☐	Stroke	☐
Arrhythmias	☐			Epilepsy or seizures	☐
Aneurysm	☐			Panic attack	☐
Other heart problems	☐			Phobias	☐

DERMAL/MUSCULOSKELETAL		PULMONARY		OTHER CONDITIONS	
Allergy to latex (Rubber)	☐	Hay fever	☐	Anxiety disorder	☐
Skin rash	☐	Sinus trouble	☐	Depression	☐
Osteoarthritis	☐	Allergies or hives	☐	Enlarge lymph node or gland	☐
Rheumatoid arthritis	☐	Asthma	☐	Tumor or Cancer	☐
Systemic Lupus	☐	Chronic cough	☐	Radiation therapy	☐
Artificial (prosthetic) joint	☐	Emphysema	☐	Chemotherapy	☐
Fibromyalgia	☐	Chronic bronchitis	☐	Sleep Apnoea	☐
Chronic Fatigue Syndrome	☐	Tuberculosis (TB)	☐	Infectious disease	☐
Dry Mouth	☐	Breathing difficulties	☐	Excessive thirst	☐
Frequently sore throat	☐	Sarcoidosis	☐	Trouble breathing through nose	☐
Muscle weakness/Cramps	☐				
Cold Sores/Herpes	☐				

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ENDOCRINE		GENITOURINARY		GASTROINTESTINAL	
Diabetes	☐	Kidney, Bladder problem	☐	Stomach/Intestinal ulcers	☐
Thyroid disease	☐	Reproductive system problem	☐	Colitis	☐
Hormone replacement therapy (HRT)	☐	"Pregnant How many weeks?"		Irritable bowel syndrome	☐
Change of libido	☐			Persistent diarrhoea	☐
				Hepatitis or liver disease	☐
				Nausea/Vomiting	☐

HEALTH & MEDICAL HISTORY *CONFIDENTIAL*

☐ Yes ☐ No	Do you drink 4 or more cups of coffee per day?
☐ Yes ☐ No	Do you smoke tobacco?
☐ Yes ☐ No	Do you consume alcohol or take sedatives?
☐ Yes ☐ No	Do you take recreational drugs?
☐ Yes ☐ No	Do you have allergies or intolerance to any medications, foods or environmental factors? If so, please list
☐ Yes ☐ No	In the last year, have you drunk or used drugs more than you meant to?
☐ Yes ☐ No	Have you felt you need to cut down on your drinking or drug use in the last year?

STOP-Bang Questionnaire

Snoring?

Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Yes ☐ No ☐

Tired?

Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?

Yes ☐ No ☐

Observed?

Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?

Yes ☐ No ☐

Pressure?

Do you have or are being treated for **High Blood Pressure**?

Yes ☐ No ☐

Body Mass Index more than 35 kg/m2?

Yes ☐ No ☐

Age older than 50 year old?

Yes ☐ No ☐

Neck size large? (Measured around Adams apple)

For male, is your shirt collar 17 inches/43 cm or larger?
For female, is your shirt collar 16 inches/41 cm or larger?

Yes ☐ No ☐

Gender = Male? Yes ☐ No ☐

1. Do you wake with a headache?

   Yes ☐ No ☐

2. Do you suffer from reflux or indigestion?

   Yes ☐ No ☐

3. Do you wake feeling good?

   Yes ☐ No ☐

Discomfort Scale

These are discomfort scales. For each part of the body there are horizontal rows, one for the left and one for the right. Please report your average discomfort for the last 7 days by circling the rating from 0 to 10 which best reflects your discomfort.

0 being no pain – 10 being unbearable pain

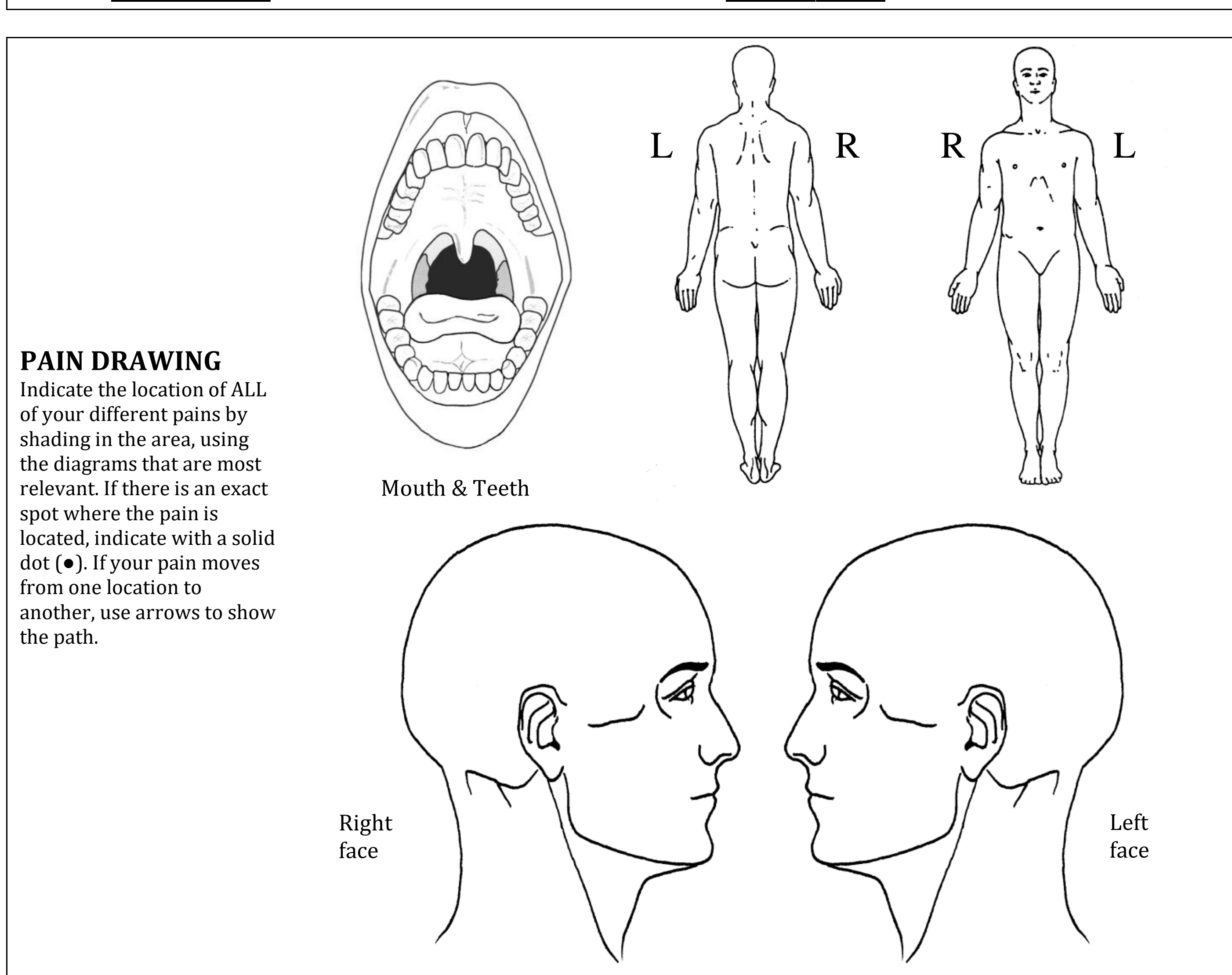
Bite symptoms or bite changes	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
TMJ joint pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
TMJ joint sounds	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Headaches	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Facial pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Eye symptoms	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Ear pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Stuffy ears or ringing sounds	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Neck pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Arm/hand/finger (numbness, tingling or pain)	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Upper back pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Lower back pain	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Pain in shoulder	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Pain on raising shoulder	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10
Difficulty raising shoulder	**R**	0	1	2	3	4	5	6	7	8	9	10
	L	0	1	2	3	4	5	6	7	8	9	10

OTHER QUESTIONS – PLEASE TICK & ANSWER IN SPACE PROVIDED

Have you suffered trauma? Where? ______________ Age when it happened : _____	☐ YES ☐ NO	Have you been involved in an accident? Age when it happened: _____	☐ YES ☐ NO
Have you had surgery? Where? ______________ When? ______________	☐ YES ☐ NO	Do you have trouble swallowing? When? ______________	☐ YES ☐ NO
Have you experienced Vertigo? (dizziness, head spins) When? ______________	☐ YES ☐ NO	Do you grind or clench your teeth? When? ______________	☐ YES ☐ NO

PAIN DRAWING

Indicate the location of ALL of your different pains by shading in the area, using the diagrams that are most relevant. If there is an exact spot where the pain is located, indicate with a solid dot (●). If your pain moves from one location to another, use arrows to show the path.



Please fill in this form, to see if we can help you with your sleep.

We treat your healthcare beyond basic dentistry.

EPWORTH SLEEPINESS SCALE

0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing	Situation	Chance of Dozing
Sitting & reading		Watching TV	
Sitting inactive in a public place (e.g. a theatre or a meeting)		Lying down to rest in the afternoon (when circumstances permit)	
As a passenger in a car for an hour without a break		Sitting & talking to someone	
Sitting quietly after a lunch without alcohol		In a car, while stopped for a few minutes in traffic	

PATIENT HEALTH QUESTIONNAIRE – 9

This evaluation is intended as a guide to the influence of your mood on the severity of your facial pain, and is not diagnostic of any psychological or psychiatric disorders. If you have concerns after completing these forms please see your general medical practitioner for the appropriate care.

Over the last 2 weeks, how often have you been bothered by the following problems? Please tick the box to indicate your answer.

		Not at all	Several days	More than half the day	Nearly every day
1	Little interest or pleasure in doing things	☐	☐	☐	☐
2	Feeling down, depressed or hopeless	☐	☐	☐	☐
3	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4	Feeling tired or having little energy	☐	☐	☐	☐
5	Poor appetite or overeating	☐	☐	☐	☐
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9	Thinking that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problems, how difficult 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
☐	☐	☐	☐

GAD – 7

Over the last 2 weeks, how often have you been bothered by the following problems?
Place tick the box to indicate your answer

		Not at all	Several days	More than half the day	Nearly every day
1	Feeling nervous, anxious or on edge	☐	☐	☐	☐
2	Not being able to stop or control worrying	☐	☐	☐	☐
3	Worrying too much about different things	☐	☐	☐	☐
4	Trouble relaxing	☐	☐	☐	☐
5	Being so restless that it is hard to sit still	☐	☐	☐	☐
6	Becoming easily annoyed or irritable	☐	☐	☐	☐
7	Feeling afraid as if something awful might happen	☐	☐	☐	☐

If you checked off any problems, how difficult 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
☐	☐	☐	☐

PATIENT HEALTH QUESTIONNAIRE – 15: PHYSICAL SYMPTOMS

This evaluation is intended as a guide to the influence of your mood on the severity of your facial pain, and is not diagnostic of any psychological or psychiatric disorders. If you have concerns after completing these forms please see your general medical practitioner for the appropriate care.

During the last 4 weeks, how much have you been bothered by any of the following problems? Please tick the box to indicate your answer.

		Not bothered	Bothered a little	Bothered a lot
1	Stomach pain	☐	☐	☐
2	Back pain	☐	☐	☐
3	Pain in arms, legs, or joints (knees, hips etc)	☐	☐	☐
4	Menstrual cramps or other problems with your periods (women only)	☐	☐	☐
5	Headaches	☐	☐	☐
6	Chest pain	☐	☐	☐
7	Dizziness	☐	☐	☐
8	Fainting spells	☐	☐	☐
9	Feeling your heart pound or race	☐	☐	☐
10	Shortness of breath	☐	☐	☐
11	Pain or problems during sexual intercourse	☐	☐	☐
12	Constipation, loose bowels, or diarrhoea	☐	☐	☐
13	Nausea, gas or indigestion	☐	☐	☐
14	Feeling tired or having low energy	☐	☐	☐
15	Trouble sleeping	☐	☐	☐

DIAGNOSTIC CRITERIA FOR TEMPOROMANDIBULAR DISORDERS SYMPTOM QUESTIONNAIRE

Patient name:_____________________________ Date:_________________

	PAIN		
1	Have you ever had pain in your jaw, temple, in the ear, or in front of the ear on either side?	☐ Yes	☐ No
	If you answered NO, then skip to Question 5.		
2	How many years or months ago did your pain in the jaw, temple, in the ear, or front of the ear first begin?	Years ___ Months ___	
3	In the last 30 days, which of the following best describes any pain in your jaw, temple, in the ear, or in front of the ear on either side?	☐ No pain ☐ Pain comes & goes ☐ Pain is always present	
	If you answered NO to Question 3, then skip to Question 5.		
4	In the last 30 days, did the following activities change any pain (that is, make it better or make it worse) in your jaw, temple, in the ear, or in front of the ear on either side?		
A	Chewing hard or tough food	☐ Yes	☐ No
B	Opening your mouth, or moving your jaw forward or side to side	☐ Yes	☐ No
C	Jaw habits such as holding teeth together, clenching/grinding teeth or chewing gum	☐ Yes	☐ No
D	Other jaw activities such as talking, kissing or yawning	☐ Yes	☐ No
	HEADACHE		
5	In the last 30 days, have you had any headaches that included the temple areas of your head?	☐ Yes	☐ No

DIAGNOSTIC CRITERIA FOR TEMPOROMANDIBULAR DISORDERS SYMPTOM QUESTIONNAIRE

If you answered NO to Question 5, then skip to Question 8.			
6	How many years or months ago did your temple headache first begin?	Years ___ Months ___	
7	In the last 30 days, did the following activities change any headache (that is, make it better or make it worse) in your temple area on either side?		
A	Chewing hard or tough food	☐ Yes	☐ No
B	Opening your mouth, or moving your jaw forward or to the side	☐ Yes	☐ No
C	Jaw habits such as holding teeth together, clenching/grinding, or chewing gum	☐ Yes	☐ No
D	Other jaw activities such as talking, kissing, or yawning	☐ Yes	☐ No

DIAGNOSTIC CRITERIA FOR TEMPOROMANDIBULAR DISORDERS SYMPTOM QUESTIONNAIRE

				Office Use Only		
	JAW JOINT NOISES	**Yes**	**No**	Right	Left	Don't Know
8	In the last 30 days, have you had any jaw joint noise(s) when you moved or used your jaw?	☐	☐	☐	☐	☐
	CLOSED LOCKING JAW					
9	Have you ever had your jaw lock or catch, even for a moment, so that it would not open ALL THE WAY?	☐	☐	☐	☐	☐
	If you answered NO to Question 9 then skip to Question 13					
10	Was your jaw lock or catch severe enough to limit your jaw opening and interfere with your ability to eat?	☐	☐	☐	☐	☐
11	In the last 30 days, did your jaw lock so you could not open ALL THE WAY, even for a moment, and then unlock so you could open ALL THE WAY?	☐	☐	☐	☐	☐
	If you answered NO to Question 11 then skip to Question 13					
12	Is your jaw currently locked or limited so that your jaw will not open ALL THE WAY?	☐	☐	☐	☐	☐
OPEN LOCKING JAW						
13	In the last 30 days, when you opened your mouth wide, did your jaw lock or catch even for a moment such that you could not close it from this wide open position?	☐	☐	☐	☐	☐
	If you answered NO to Question 13 then you are finished.					
14	In the last 30 days, when your jaw locked or caught wide open, did you have to do something to get it close including resting, moving, pushing, or maneuvering it?	☐	☐	☐	☐	☐

JAW FUNCTIONAL LIMITATION SCALE

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'. If you avoid an activity for reasons other than pain or difficulty, leave the item blank.

		No limitation										**Severe limitation**
1	Chew tough food	0	1	2	3	4	5	6	7	8	9	10
2	Chew hard bread	0	1	2	3	4	5	6	7	8	9	10
3	Chew chicken (eg, prepared in the oven)	0	1	2	3	4	5	6	7	8	9	10
4	Chew crackers	0	1	2	3	4	5	6	7	8	9	10
5	Chew soft food (eg, macaroni, canned or soft fruits, cooked vegies, fish)	0	1	2	3	4	5	6	7	8	9	10
6	Eat soft food requiring no chewing (eg; mashed potato, apple sauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10
7	Open wide enough to bite from a whole apple	0	1	2	3	4	5	6	7	8	9	10
8	Open wide enough to bite into a sandwich	0	1	2	3	4	5	6	7	8	9	10
9	Open wide enough to talk	0	1	2	3	4	5	6	7	8	9	10
10	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10
11	Swallow	0	1	2	3	4	5	6	7	8	9	10
12	Yawn	0	1	2	3	4	5	6	7	8	9	10
13	Talk	0	1	2	3	4	5	6	7	8	9	10
14	Sing	0	1	2	3	4	5	6	7	8	9	10
15	Putting on a happy face	0	1	2	3	4	5	6	7	8	9	10
16	Putting on an angry face	0	1	2	3	4	5	6	7	8	9	10
17	Frown	0	1	2	3	4	5	6	7	8	9	10
18	Kiss	0	1	2	3	4	5	6	7	8	9	10
19	Smile	0	1	2	3	4	5	6	7	8	9	10
20	Laugh	0	1	2	3	4	5	6	7	8	9	10

GRADED CHRONIC PAIN SCALE

1	On how many days in the last 6 months have you had facial pain?	_________ days										
		No Pain										**Severe Pain**
2	How would you rate your facial pain **RIGHT NOW**?	0	1	2	3	4	5	6	7	8	9	10
3	In the last 30 days, how would you rate your **WORST** facial pain?	0	1	2	3	4	5	6	7	8	9	10
4	In the last 30 days, **ON AVERAGE**, how would you rate your facial pain? That is, your usual pain at times you were in pain.	0	1	2	3	4	5	6	7	8	9	10
5	In the last 30 days, how many days did your facial pain keep you from doing your **USUAL ACTIVITIES** like work, school or housework?	__________ days										
		No Interference										**Unable to do activity**
6	In the last 30 days, how much has facial pain interfered with your **DAILY ACTIVITIES?**	0	1	2	3	4	5	6	7	8	9	10
7	In the last 30 days, how much has facial pain interfered with your **RECREATIONAL, SOCIAL & FAMILY ACTIVITIES?**	0	1	2	3	4	5	6	7	8	9	10
8	In the last 30 days, how much has facial pain interfered with your **ABILITY TO WORK**, including housework?	0	1	2	3	4	5	6	7	8	9	10