Dr. James F.M. Yanney, D.D.S., M.D.
1672 Willamette Falls Drive Suite D
West Linn, Oregon 97068
Phone: (503) 722-4377

PATIENT INFORMATION

Completion of this information, in its entirety, is required at time of visit

A. Personal Information:

Name:______________________________________ Male______ Female ________

Birthdate:_______________ Social Security Number (SSN):____________________

Material Status (check one): Single_____ Married _____ Divorced_____ Separated ______

Home Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Employer: ___________________________ Occupation: ____________________

Employer Address: __________________________ Work Phone: ________________

Spouse/Parent Name:____________________ Birthdate:_________ SSN:___________

Spouse/Parent Home Phone: _______________Spouse/Parent Cell Phone:____________

Spouse/Parent Home Address: ____

Spouse/Parent Employer Address: ___________________ Work Phone:______________

B. Physician Information:

Name of your regular physician:___________________ Phone Number:_____________

Physician Address: ____

C. If someone other than the patient is responsible for payment please complete the following:

Name of responsible party:__________________ Address: ______________________

Relationship to patient:____________ SSN:__________ Home Phone:______________

Employer:______________ Address:________________ Work Phone:_____________

D. In case of Emergency:

Relative to contact (other than spouse):________________ Phone Number:_______________

Other person to contact (not relative): _________________ Phone Number: _______________

E. How do you intend to pay?

Cash ______Check______Credit Card______Insurance______Medicare______Other ________

INSURANCE INFORMATION (Important! Please give us ALL insurance information):

Primary Insurance Co.: ____

Complete Insurance Co. address: ____

____________________________ Insurance Co. phone number: _______________________

Policy/ID number: ______________________ Group number: ___________________________

Name of primary person on insurance: ____

Primary person's social security number: _____________________ Birthdate: ______________

F. Reason for this visit:

Referral from: _________________________ MD_____DDS_____DMD_____Chiropractor_____

Referring doctor's phone number:____

Referring doctor's address: ____

Are you here due to: Illness______ Injury______ Job related injury ______ Auto Accident _____

Other_____ Date of injury or onset of condition:__________________

Explain symptoms:____

Workers Compensation Carrier (if job related) _______________________________________

Name of Claims Manager: __________________________ Phone Number: ________________

G. Please read the following, sign, and return to the receptionist:

We would like the patient to understand that we bill your insurance company as a courtesy to you. We would further like the patient to understand that after 30 days, you are FULLY responsible for any outstanding balance due on your account.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to proceed with collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, to include reasonable attorney fees. I also authorize the doctor to release information necessary to secure payments of benefits.

Signature:____________________________________ Date: ___________________

HISTORY QUESTIONNAIRE

Name: ______________________________ Age: ______ Date: ____________

Chief Complaint: ____
____

Family History – (Give age if living; or age and cause of death)

Father: ______________________ Siblings: ________________________________
Mother: ______________________ Children: ________________________________

Immediate family history - (blood relatives only – indicate which, if any, are present):

Heart trouble	No	Yes
Bleeding tendency	No	Yes
Diabetes	No	Yes
High blood pressure	No	Yes
Stroke	No	Yes
Keloid formation	No	Yes
Cancer	No	Yes

Other ____

Allergies and sensitivities – (Indicate if any of the following are present):

Penicillin	No	Yes
Other antibiotic	No	Yes
Xylocaine	No	Yes
Codeine	No	Yes
Aspirin	No	Yes
Tetanus toxoid	No	Yes
Adhesive tape	No	Yes

Other ____

Medications – (Indicate any that currently apply):

Type:	Dosage:	Frequency:
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

____

cortisone, ACTH, other steroids
sedatives, sleeping pills, tranquilizers
blood pressure regulators
digitalis, nitroglycerine, any cardiac drugs
thyroid
insulin, any diabetes regulators
appetite suppressants
Other

Tobacco: None______ 1 pack/day or less______ 2 packs/day or more_____

Alcohol: None______ Socially______________ Daily______________

Use of any drugs: Marijuana________ Cocaine_________ Other___________

Blood pressure:________ Height:______________ Weight:____________

Surgical History - List all prior operations (to include cosmetic surgery and peels):

Type: Location: Approximate date: Surgeon:

____

____

____

Did any problems or complications occur during or after any of the above? YES NO

If yes, please explain: ____

Past Medical History – List any other prior hospitalizations below:

Purpose: Location: Approximate date: Physician:

____

____

____

Have you been recently under the care of any physician for any particular reason: ______

If so, description and treatment ______________________________________

Family physician ______________________ Date of last exam __________

Review of systems - (Indicate which, if any, apply to you):

Skin disease..	No	Yes
Eye, ear, nose, throat	No	Yes
Thyroid	No	Yes
Palpitations	No	Yes
Diabetes..	No	Yes
Shortness of breath, chronic cough	No	Yes
Chest pain, heart murmur............................	No	Yes
Rheumatic fever....................................	No	Yes
Anemia, bleeding tendencies, bruisability	No	Yes
Arthritis..	No	Yes
Liver..	No	Yes
Psychiatric	No	Yes

Any medical history not noted above which you feel the doctor should be aware of:

____

____

____

____

____

Oral, Maxillofacial, Reconstructive T.M.J.
And Orthognatic Surgery Clinic

PLEASE USE PEN

Name____________________________________Age_______Birthdate____/____/____

Date you received this form: ____/____/____

As soon as you receive this form and **before** reading any of the questions to follow, please list the complaint(s) or reason(s) for which you are coming to see me:

____

____

____

____

How long have you been diagnosed with, or feel you have, this problem: ____________________

Fill out this questionnaire following the instructions below:

Please take your time in answering the following questions. Take time to observe yourself prior to your appointment and complete this form **before** you see Dr. Yanney. Circle **YES, NO,** or **BOTH**, when applicable. You may also write in comments, if you need to further explain. PLEASE answer ALL of the questions!

Some patients who are referred for consideration for corrective jaw surgery may feel that none of these questions are applicable to them, as they may not have pain complaints. I still wish for you to carefully read, and answer, all of the following questions.

		CIRCLE	
1.	Do you experience pain during the act of chewing? If yes, is it *right* sided, *left* sided, or on *both* sides? (circle response)	NO	YES
2.	Do you notice pain in your temples or forehead 30 minutes to several hours after chewing? If yes, *right, left,* or *both*? (circle response)	NO	YES
3.	Do you notice pain in your face 30 minutes to several hours after chewing? If yes, *right, left,* or *both*? (circle response)	NO	YES
4.	Do you experience pain when swallowing? If yes, *right, left,* or *both*? (circle response)	NO	YES

THE JAW JOINTS ARE RIGHT IN FRONT OF EACH EAR. REACH UP AND FEEL THEM AS YOU OPEN AND CLOSE YOUR MOUTH

5.	Do you experience pain in your jaw joints? If yes, *right, left,* or *both*? (circle response)	NO	YES

6. Do you experience pain when yawning? NO YES
If yes, *right*, *left*, or *both*? (circle response)

7. Do you experience pain when biting into something with your front teeth? NO YES
If yes, *right, left*, or *both*? (circle response) If yes, please specify – is the pain in the teeth or is the pain somewhere else? Where?

____

8. Do you experience pain when chewing with your back teeth? If yes, *right, left*, or *both*? (circle response) If yes, please specify – is the pain in the teeth or is the pain somewhere else? Where? NO YES

____

9. Do you experience any sharp, shooting, electrical-like pains in your face? NO YES
If yes, *right, left* or *both*? (circle response) If yes, please specify – is the pain in the teeth or is the pain somewhere else? Where?

____

10. If you answered YES to question #9, how many times a day might you experience these pains? ____

READ THE NEXT SEVEN QUESTIONS <u>BEFORE</u> ANSWERING ANY OF THEM. If you answer "YES" to #11, try to give the <u>single</u> best answer to questions #12 thru #17.

11. Do you have pain in your **facial** area? NO YES
12. Is your pain **only on the right side**? NO YES
13. Is your pain **only on the left side**? NO YES
14. Is your pain **basically equal on both sides**? NO YES
15. Is your pain on both sides; **but more on the right side?** NO YES
16. Is your pain on both sides; **but more on the left side?** NO YES
17. Is your pain on both sides; **but varies from side to side in intensity**? NO YES

On a scale of 1 to 10, with 1 being very slight pain occurring monthly or less, 5 being daily pain which requires medication, and 10 being constant, severe pain, **please circle** where you are on the scale:

Jaw joint pain	0	1	2	3	4	5	6	7	8	9	10
Earache	0	1	2	3	4	5	6	7	8	9	10
Neck pain	0	1	2	3	4	5	6	7	8	9	10
Headache in front	0	1	2	3	4	5	6	7	8	9	10
Headache in back	0	1	2	3	4	5	6	7	8	9	10
Headaches in temples	0	1	2	3	4	5	6	7	8	9	10
Other ____________	0	1	2	3	4	5	6	7	8	9	10

18. Do you engage in biting your finger nails, lips, cheeks, pencils, or chewing gum? (If yes, circle whichever applies) NO YES

19. Do you feel like you clench your teeth during the day, during moments of stress or anger, concentration, driving, or typing? (If yes, circle whichever applies) NO YES

20. Do you experience tiredness in your facial muscles during or after vigorous chewing of food? NO YES

21. Does talking cause you to experience any pain or tiredness in your face or joint areas? (If yes, circle whichever applies) NO YES

22. Have you ever injured your lower jaw? If yes, please explain NO YES
____

23. Have you ever had a whiplash injury? NO YES
If yes, when? ____

24. Have you ever dislocated your jaw such that it was stuck wide open? If yes, when was the first time? When was the last time? No YES
____

25. Has your jaw *ever* become caught or stuck so that you could not achieve full opening? If yes, *right, left* or *both*? (circle response) If yes, does it still do this? YES or NO (circle response) Can you estimate how long ago it stopped? NO YES
____

26. Has your jaw *ever* locked so that you cannot close it all the way together? If yes, *right, left*, or *both*? (circle response) If yes, does it still do this? YES or NO (circle response) Can you estimate how long ago it stopped locking? NO YES
____

THE JAW JOINTS ARE RIGHT IN FRONT OF YOUR EARS. PLEASE PUT YOUR FINGERS IN FRONT OF YOUR EARS AND MOVE YOUR JAW. OPEN AND CLOSE AND WIGGLE IT FROM SIDE TO SIDE TO DETERMINE WHAT YOU FEEL OR HEAR. WHEN I ASK ABOUT JOINT "NOISE", I MEAN SOUNDS THAT MOST PEOPLE WOULD CALL POPPING, CLICKING, CRACKING, SNAPPING, GRINDING, OR SCRAPING. THE FIRST FOUR QUESTIONS BELOW ARE VERY SIMILAR. PLEASE NOTE: GRINDING AND SCRAPING ARE VERY DIFFERENT FROM THE FIRST FOUR "NOISES" DESCRIBED.

27. Can you recollect *ever* experiencing popping in your jaw joint(s) upon awakening or shortly after awakening, which then stops after moving the jaw for a few minutes? If yes, *right, left*, or *both*? (circle response) NO YES

28. Can you recollect having experienced noises in your jaw joint(s) at some point in the past BUT now you recognize these noises have either "stopped" or have "changed"? (If yes, please circle whichever applies) NO YES

29. Have you noticed noise in your RIGHT joint recently? NO YES
Describe the noise: ____
How recently? ____

30. Have you noticed noise in your LEFT joint recently? NO YES
Describe the noise: ______________________________
How recently? ______________________________

31. Have you ever had to manipulate your jaw in order to get it to open fully? NO YES
Describe: ______________________________

HEADACHES ARE NOT ALL CAUSED BY THE SAME THING. ALL HEADACHE PAIN IS NOT CONFINED TO ANY ONE OR SEVERAL AREAS OF THE HEAD. ALL DIAGNOSES IN REGARD TO THE CAUSE OF HEADACHE PAIN MADE BY THE PATIENT, BY ANY DOCTOR, OR MADE BY ME ARE NOT ALWAYS CORRECT. OFTEN HEADACHE PATIENTS HAVE MORE THAN ONE TYPE OF HEADACHE. THERE IS NO SINGLE TYPE OF TREATMENT THAT WILL "CURE" OR MANAGE ALL TYPES OF HEADACHES. NINETY PERCENT (90%) OF HEADACHE PAIN IS CAUSED BY MUSCLES THAT ARE ON OUR SKULLS. APPROXIMATELY 90% OF THE PATIENTS I SEE DO NOT KNOW THAT HEADACHES MAY BE A SYMPTOM OF SOME PROBLEM WITH THE CHEWING SYSTEM. APPROXIMATELY 75% OF THE PATIENTS I SEE HAVE SOME OF THEIR HEADACHES BECAUSE OF SOME PROBLEM(S) WITH THEIR CHEWING SYSTEM.

32. Regardless of what you think or know to be the cause of your headaches, how many headaches do you experience per average week? ________ Worse week? ________ Best week? ________

33. Do you consider some of your headaches to be severe? NO YES
How often do you experience what you consider to be a severe headache? ______________________________
Are these severe headaches preceded by any difficulties with your vision? NO YES
Are these severe headaches associated with nausea and/or vomiting? NO YES

34. Do you feel you experience more than one type of headache? NO YES

35. List the types of headaches you experience, as you see them?
____
____

36. Has a physician ever told you that you have migraine headaches? NO Yes

37. Have you ever taken any migraine headache medications? NO YES

38. Have you ever been hospitalized for any tests in regard to headaches? NO YES

TENSION HEADACHES CAN BE FELT IN THE BACK OF THE HEAD, IN THE FOREHEAD, IN ONE OR BOTH SIDES AT THE TEMPLES, OR IN SEVERAL LOCATIONS AT THE SAME TIME.

39. Do you think you experience "tension headaches"? NO YES

40. Which part of your head is affected if you feel you have tension headaches?
____
List the location, in order of frequency, you believe you experience tension headaches: ______________________________
____
____

41. How often do you awaken with a headache present? ______________________
If you do, to what do you attribute these headaches? ______________________
____

YOU MAY MARK MORE THAN ONE OF THE FOLLOWING:

42. When is your most <u>frequent</u> type of headache worse?
    Upon awakening ____________ In the morning and before lunch __________
    Within 2 hours after lunch ___________ Between 2 p.m. and 6 p.m. ____________
    Within 2 hours after the evening meal _______ Before you go to bed _______________
    Awaken during the night with headache ____________

43. Do you have brothers or sisters who experience frequent or severe headaches? NO YES

44. Do either of your parents experience frequent or severe headaches? NO YES

45. If you have children, do any of them experience frequent or severe headaches? NO YES

46. If you experience frequent or severe headaches, do you have high blood pressure? NO Yes

47. Do you ever awaken from sleep <u>because</u> of a headache? NO YES
    If yes, to what do you attribute this type of headache? ______________________
    ____

READ THE NEXT SEVEN QUESTIONS <u>BEFORE</u> ANSWERING ANY OF THEM. If you answer "YES" to #48, try to give the <u>single</u> best answer to questions #49 thru #54

48. Do you have <u>headaches</u>? NO YES

49. Is your headache pain <u>only on the right side</u>? NO YES

50. Is your headache pain <u>only on the left side</u>? NO YES

51. Is your headache pain basically <u>equal on both sides</u>? NO YES

52. Is your headache pain on <u>both</u> sides; but <u>more on the right side</u>? NO YES

53. Is your headache pain on <u>both</u> sides; but <u>more on the left side</u>? NO YES

54. Is your headache pain on <u>both</u> sides; but <u>varies from side to side in intensity</u>? NO YES

The following foods are known to cause headaches in <u>some</u> individuals: Ripened cheeses (Cheddar, Emmentaler, Gruyere, Stilton, Brie, and Camembert); Pickled herring; Chocolate; Vinegar (except white vinegar); Foods that are fermented, pickled, or marinated; Fermented sausage (bologna, salami, pepperoni, summer sausage, and hot dogs); Sour cream and yogurt; Nuts; Peanut butter; Hot fresh breads, raised coffee cakes, and doughnuts; Pods of broad beans (lima, navy, and pea pods); Food containing large amounts of monosodium glutamate (Chinese food); Onions; Canned figs; Citrus fruit and citrus food, to include bananas; Pizza; Pork; Excessive tea, coffee, and cola beverages; Avocado (Guacamole dip); Chicken livers; Alcoholic beverages, especially red wine

55. Do you presently recognize any of the above substances as causing some of your headaches? If so, please circle the foods mentioned above that you may relate to your headaches. **Do not circle anything just because you may eat it...circle <u>only</u> if you believe or know it causes headaches in you.** NO YES

56. Name any other food (not mentioned above) that you think might cause a headache: ____________________

The following questions are asked with the assumption that you have a "normal" sleep routine. You generally go to sleep between 9 p.m. and midnight and get up between 5 a.m and 8 a.m.. If this is **<u>not</u>** true for you, please explain what your usual sleep time is: ____________________

____

BEFORE ANSWERING QUESTIONS #57 AND #58 BELOW, ASK ANYONE YOU CAN THINK OF WHO MIGHT HAVE HAD THE OPPORTUNITY TO HEAR YOU MAKE TEETH GRINDING NOISES. DO NOT ASSUME THAT YOU DON'T GRIND YOUR TEETH WHILE SLEEPING <u>JUST BECAUSE</u> NO ONE HAS TOLD YOU THAT THEY HAVE HEARD YOU GRINDING YOUR TEETH! PLEASE ASK THEM!!

57. Has anyone ever heard you grinding your teeth while you sleep at night? If yes, as a <u>child</u>, an <u>adult</u>, or <u>both</u>? (Circle applicable answer) NO YES

58. Has anyone ever heard you grinding your teeth while taking a nap? NO YES

59. Do you have <u>parents</u>, <u>brothers</u>, <u>sisters</u>, or <u>children</u> who grind their teeth while sleeping? (If yes, circle those that apply) NO YES

PLEASE OBSERVE YOURSELF CAREFULLY, FOR AS MANY NIGHTS AS POSSIBLE, BEFORE ANSWERING THE NEXT FOUR QUESTIONS.

60. Do you notice yourself awakening with your teeth clenched? NO YES

61. Do you notice yourself going to sleep with your teeth clenched? NO YES

62. Do you have stiffness in your jaws upon awakening from your usual sleep? NO YES

63. Do you notice that your teeth are sore upon awakening from your usual sleep? NO YES

64. Do you feel that your dreams are unpleasant or stressful? NO YES
If yes, and if you can determine, are these dreams more likely to occur in the first half or second half of your sleep time? (Circle applicable answer)

65. How often per week do you have "bad dreams"?________________________________

66. In your own words, describe your sleep in regard to restfulness and soundness. ** **THIS IS A VERY IMPORTANT QUESTION. PLEASE TAKE THE TIME TO PROVIDE AS ACCURATE A STATEMENT AS POSSIBLE. MENTION ANY DIFFICULTIES SUCH AS...1) TROUBLE GOING TO SLEEP...2) FREQUENT AWAKENINGS, OR...3) EARLY AWAKENING WITH THE INABILITY TO RETURN TO SLEEP.**

____

____

____

67. If you have a sleeping partner, does he or she sleep more soundly than you sleep? NO YES

68. Has anyone ever noticed you to react physically by talking, moving, or acting frightened in response to your dreams? NO YES

69. On the average, how many times during the night do you get up to go to the bathroom?________________________________

Do you get up for any other reason?________________________________

70. How many hours of sleep do you usually obtain?________________________________

71. How often do you sleep less than the amount you mentioned in #70 above?
____

72. How often do you exceed the amount of sleep you mentioned in #70 above?
____

73. How often do you take a nap?________________________________

74. How long are your average naps?________________________________

75. Do you notice you are more likely to have a headache on the days that you "over" sleep? NO YES

76. Do you usually have any problem staying awake in the daytime? NO YES

77. If you have pain in your face, jaws, joints, or temples, does sleep help lessen it or does sleep worsen it?________________________________

78. Do you presently experience earaches? NO YES
If yes, *right*, *left* or *both*? (circle response)

79. Do you feel you have decreased hearing? NO YES
If yes, *right*, *left* or *both*? (circle response)

80. Do you experience symptoms of stuffiness, fullness, or frequent popping in your ears? (please circle those that apply) NO YES

81. Do you experience vertigo or dizziness presently? NO YES

82. If yes, is anyone treating you for vertigo or dizziness? NO YES
If yes, whom?______________________________

83. Have you experienced vertigo or dizziness in the past to the extent that you have sought medical advice about it? NO YES

84. Do you experience ringing in your ears? NO YES
If yes, *right*, *left* or *both*? (circle response)

85. Do normal sounds seem unusually loud? NO YES

86. If you have an ear problem, are you being treated by an Ear, Nose and Throat Specialist? Another physician? If yes, whom? NO YES
____

87. Have you ever been hospitalized for any tests in regard to ear problems? NO YES

88. Have you ever had ear surgery? NO YES
If yes, *right*, *left* or *both*? (circle response)

89. Have you ever had your hearing tested? NO YES
If yes, approximately when?______________________________

90. If you had your hearing tested, has your hearing decreased? NO YES
If yes, *right*, *left* or *both*? (circle response)

91. At times of facial or head pain, which you may feel are your sinuses, are you able to blow discolored mucous out of your nose? NO YES

Do you notice discolored mucous draining from the back of your throat or nose? NO YES

92. Have your sinuses been examined by an Ear, Nose, and Throat Specialist? If yes, approximately when?______________________________ NO YES

What did she/he find?______________________________

93. Have you ever had your sinuses x-rayed? NO YES
If yes, approximately when?______________________________

94. Do you experience neck stiffness? NO YES

95. Does turning your head cause you any symptoms? NO YES
If yes, please explain:______________________________

96. Do you have <u>neck</u> or <u>shoulder</u> pain? NO YES

97. Do you have any other joints or muscles that ache or are painful for which there has been no adequate explanation? If yes, please explain: ______ NO YES

98. Have you ever been diagnosed as having Rheumatoid Arthritis, Gout, Osteoarthritis, Lupus, Psoriasis, Scleroderma, or Anklyosing Spondylitis? If yes, please circle whatever applies. Write when diagnosed and by whom: ______ NO YES

99. Are you recently experiencing any nose bleeds? NO YES

100. Have you ever been diagnosed as having any kind of tumor? If yes, please write what kind: ______ NO YES

101. Do you experience numbness or tingling sensations in your face, head, or mouth? If yes, please describe: ______ NO YES

102. Did you experience any major emotional difficulties with the past 6 months preceding the onset of any painful symptoms (symptoms related to you seeing me?) If yes, please explain: ______ NO YES

103. If you are someone with pain, are there major stressful events taking place in your life presently? Is this more than before this pain may have begun? If yes, please explain: ______ NO YES

104. Have you ever taken any tranquilizing drugs? NO YES

105. Have you ever taken any antidepressants? NO YES

106. Have you ever been treated by a Psychiatrist? NO YES
Have you been recommended to see a Psychiatrist? NO YES
If yes, when? ______ Did you go? ______

107. Are you presently depressed, as far as <u>you</u> are concerned? NO YES

108. Have you worn braces for a bite problem or crooked teeth? NO YES

109. Have you ever worn a night guard or splint because of a facial pain problem? NO YES

110. Have you ever had biofeedback treatment for facial or headache pain? NO YES

111. Have you ever had any physical therapy to your scalp or facial muscles because of pain? NO YES

112. Have you been treated by a Chiropractor? NO YES
If yes, for what kind of problem? ______
If yes, when was the last time you were treated? ______

113. Have you ever had your teeth ground in an attempt to deal with any facial, dental, or other pain that you may have had in the past or may have presently? NO YES

114. Have you ever had your jaw joints injected with cortisone or similar drugs? NO YES

IF YOU HAVE FACIAL, DENTAL, HEAD, OR EAR PAIN WHICH HAD A RATHER SUDDEN ONSET, CAN YOU RELATE ITS ONSET TO ANY OF THE FOLLOWING?

115. It was first noted while chewing? NO YES

116. It was first noted while or after yawning? NO YES

117. It was noted to be present upon awakening? NO YES

118. It was first noted following an accident? NO YES

119. It was first noted during or right after dental care? NO YES
If yes, can you recollect what type of dental procedure you may have been undergoing?____________________

120. It was first noted after being put to sleep for an operation under general anesthesia? NO YES

121. It was first noted due to some other cause, or you do not know? NO YES
If it began after some other cause and you know the cause, will you please explain:____________________

122. Have you ever taken any of the following medicines? Please circle the medicine if you believe you have taken it.

Halycon	Valium	Librium	Triavil	Pertofrane	Nalfon	Permitil	Rufen
Ascendin	Miltown	Elavil	Aventyl	Fiorinal	Dolobid	Prolixin	Advil
Meprobamate	Dalmane	Trofranil	Deprol	Corgard	Serentil	Nuprin	Orap
Thorazine	Restoril	Ludiomil	Endep	Inderal	Meclomen	Trilifon	Xanas
Desyrel	Ativan	Limbitrol	Etrafon	Adapin	Clinoril	Navane	Haldol
Benadryl	Percogesic	Centrax	Traxene	Marplan	Pamelor	Fenopron	Valmid
Padipam	Menrium	Placidyl	Nardil	Parnate	Indocin	Lopressor	Moban
Amitriptyline	Sinequan	Serax	Norpramin	Tandearil	Inderide	Zorprin	Surmontil
Vivactil	Mellaril	Noludar	Feldene	Trancopal	Tenormin	Calan	Compazine
Stelezine	Lithium	Doriden	Naprosyn	Tolectin	Disalcid	Isoptin	Butazolidin
Noctec	Nembutal	Valrelease	Ponstel	Encapriin	Motrin	Anaprox	Bufferin
Meprosan	Equanil	Pathibamate	Procardia	Loxitine			

123. Please list ALL prescription medicines that you have been recently taking from any doctor as well as those you may be taking from over-the-counter purchases. LIST the dosages of all medicines. I wish to know about Aspirin, Bufferin, Tylenol, and similar medicines. LIST how often you presently take the medicine(s):

124. Please list anything to which you are allergic. Include prescription and over-the-counter medications, along with any foods you are allergic to:

____

____

____

____

125. Do you <u>have</u> or have you <u>had</u> stomach ulcers? If yes, circle which. NO YES

126. Do you have difficulty taking medicines that contain Aspirin? NO YES

127. Is there anything else about your problem that has not been asked that you think I should know? NO YES

____

____

____

____

128. If you are someone who has pain in the face, neck, head, or jaws, please tell me how this pain prevents you from doing tasks on a day-to-day or week-to-week basis:

____

____

____

____

129. Thank you for looking at yourself more carefully. Will you now list your complaints in order of what is the MOST bothersome to you while carrying on your day-to-day life? **Please "circle" if the complaint is on the *right*, the *left*, or on *both* sides, as applicable.**

	Right	Left	Both
1. ______________	Right	Left	Both
2. ______________	Right	Left	Both
3. ______________	Right	Left	Both
4. ______________	Right	Left	Both
5. ______________	Right	Left	Both
6. ______________	Right	Left	Both
7. ______________	Right	Left	Both
8. ______________	Right	Left	Both
9. ______________	Right	Left	Both
10. ______________	Right	Left	Both

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION

130. At the time you completed this questionnaire, is your pain/problem the same, better, or worse? (please circle one response)

131. Who is your regular dentist? ____________________

Dentist address, including zip code: ____________________

Dentist telephone number: ____________________

132. Are there any questions that I did not ask that you think I should have asked?

133. At the time you completed this questionnaire, is your pain/problem the same, better, or worse than when you made an appointment to see me? (please circle one response)

134. Whom may we thank for referring you to this office? ____________________