CMCP HISTORY

COMPLIMENTS OF BIO-RESEARCH ASSOCIATES, INC

PATIENT NAME:_____ AGE:____ SEX:____ DATE:_____

Please list below any physicians (internal medicine, ENT, neurologists, orthopedists, psychiatrists, psychologists, dentists, chiropractors, osteopaths, or physical therapists that you have consulted.

Dr. _____MD/DDS Specialty _____ City _____
Diagnosis _____ Treatment _____

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Diagnosis _____ Treatment _____

Dr. _____MD/DDS Specialty _____ City _____
Diagnosis _____ Treatment _____

Please answer the following questions, add comments, and feel free to use the back of each page if needed.

1. Have you had an injury to or been hit in the jaw or face? YES/NO
2. Have you had whiplash or been injured to the neck or back? YES/NO
3. Have you ever had cervical traction? YES/NO
4. Have you ever worn a neck brace? YES/NO
5. How long have you had your pain problem? _____
6. Have you had any treatment for this problem? _____
7. Have you had orthodontic treatment: YES/NO
   Name of orthodontist _____
8. Were any teeth extracted for orthodontic reasons? YES/NO
9. Have you had your wisdom teeth removed? YES/NO
10. Have you ever had general anesthesia? YES/NO
11. Do you have allergies as a child? YES/NO
12. Were you often sick as a child? YES/NO
13. Are you a mouth breather? YES/NO
14. Has your bite ever been adjusted by a dentist? YES/NO
    If yes, explain when _____
    _____
15. Do you attribute your symptoms to any one incident? YES/NO
    If, yes explain _____
    _____
16. Have you had cortisone injected into your joint? YES/NO
    If yes, when _____
    By Whom _____
17 Are you now on any type of pain medication? YES/NO

If yes, what kind and how often? _____

_____

18. Do you clench your teeth during the day? YES/NO
19. Has anyone mentioned that you grind your teeth (brux) at night during sleep? YES/NO
20. Do you chew gum? YES/NO
    Frequently ___ Infrequently ___ Moderately ___ Never ___
21. Is your pain worse in the mornings ___, afternoons ___, evenings ___, after eating ___, other ___.
22. Does anyone else in your family have a similar problem? YES/NO
    If yes, explain _____

    _____
23. Do you have any skin problems? YES/NO
    If yes, explain _____

    _____
24. Do you develop colds frequently? YES/NO
25. Do you tend to get cold sores? YES/NO
    Canker sores? YES/NO
26. Do you ever develop a sore tongue? YES/NO
27. Is your pain: Dull ___ Throbbing ___ Stabbing ___
    Continuous ___ Intermittent ___ Other ___
28. When did you first notice the pain? _____
29. Has your pain recently become worse? YES/NO
30. Do your problems interfere with your normal lifestyle, including your job? YES/NO
31. Do you have difficulty in chewing? YES/NO
32. Has your mouth ever locked open? YES/NO
33. Have you ever had times when your jaw would <u>not</u> open? or was limited in opening? YES/NO
    If yes, when _____
34. How does nervous tension seem to affect your pain?

    _____
35. Is your family life stressful? YES/NO
36. Is your job stressful? YES/NO
37. What aspect of your problem concerns you the most?

    _____
38. Have you been treated orthopedically (i.e. fractures, sprains, torn ligaments, in any part of the body? YES/NO
39. <u>Women</u>
    a. Have you had a full or partial hysterectomy? YES/NO
    b. Do your nails break easily? YES/NO
    c. Is your skin dry? YES/NO
    d. Does cold weather bother you? YES/NO
    e. Do you tire easily? YES/NO

f. Are your pain symptoms intensified or aggravated by your menstrual cycle? YES/NO

g. Do you take hormones or birth control pills? YES/NO

40. Nutritional Data

a. Do you read the ingredients on food labels? YES/NO

b. Do you minimize your intake of sugar? YES/NO

c. Do you generally eat whole grain flour products? YES/NO

d. Do you drink milk? YES/NO

e. Do you eat red meat products? YES/NO

f. Do you drink tea or coffee? YES/NO

g. Do you use tobacco? If yes, how much _____ YES/NO

h. Is your diet medically supervised? YES/NO

i. Do you take vitamin supplements? YES/NO

j. Do you usually eat Breakfast ____ Lunch ____ Dinner ____
Between Meals ____ Before Bed ____

k. Do you salt your food? YES/NO

41. Sleeping Disorders

a. Do you wake up from time to time during the night? YES/NO

b. Do you sleep during the day? YES/NO

c. Do you fall asleep while driving a car or reading? YES/NO

d. Do you snore? YES/NO

e. Do you have sleep apnea (interrupted breathing during sleep)? YES/NO

42. Please write any pertinent information that has not been covered previously. Write on the back if necessary. _____
_____
_____

43. Name of doctor or person who recommended you to the Craniomandibular-Cervical Pain Center _____

44. What is the date of your last appointment with your physician for these pains? symptoms? _____

45. Are you presently receiving treatment from this physician?
If so, describe _____

46. Is there any other medical reason, which may be causing your pain problems?
If so, describe _____