FACIAL PAIN HISTORY FORM

Please bring these forms to your appointment,
or fax them to 310 271-1169
or scan/email them to
officemanager@beverlyhillsdds.com

Patient's Name: _____ Date _____

Date of Birth: _____ Age: ____ Sex: Male Female

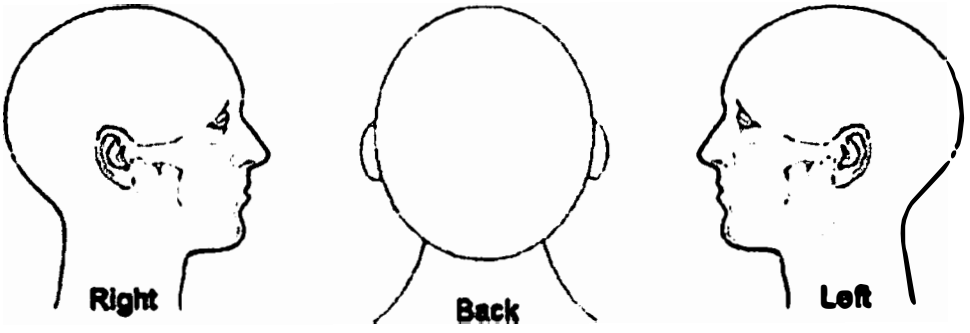
SSN/SIN: _____

Address: _____

City: _____ State: _____ Zip/Postal Code: _____

Cell Phone: _____ Email: _____

Referred by: _____



MAJOR REASON FOR CURRENT EVALUATION:

1) Indicate on above diagrams where you have the most pain

2) Describe what you think the problem is: _____

_____

2) What do you think caused this problem? _____

3) Describe, in order (first to last), what you expect from your treatment:

_____

GENERAL HISTORY:

1) Are you presently under the care of a physician, or have you been in the past year? YES NO

Physician's name: _____ Condition treated: _____

Treatment: _____

Name of medication(s) you are currently taking:

_____

_____

2) How would you describe your overall physical health?

Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

3) How would you describe your dental health?

Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Dentist's name: _____ Date of last appointment: _____

4) Have you had any major dental treatment in the last two years? YES NO

If yes, please mark procedure(s):

Orthodontics

Periodontics

Oral Surgery including bone augmentation/ sinus lifts Restorative including implants

Date(s) of Third Molar (wisdom tooth) extraction(s): _____

FACIAL INJURY/TRAUMA HISTORY:

1) Is there any childhood history of falls, accidents, or injury to the face or head? YES NO

Describe: _____

2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)
YES NO
Describe: _____

3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument) YES NO
Describe: _____

PAIN/TMD TREATMENT HISTORY:

No Pain Moderate Pain Severe Pain

1) Have you ever been examined for a PAIN/TMD problem before? YES NO

If yes, by whom? _____ When? _____

2) What was the nature of the problem? (Pain, noise, limitation of movement) _____

3) What was the duration of the problem? Months Years Is this a new problem? YES NO

4) Is the problem getting better, worse or staying the same? _____

5) Have you ever had physical therapy for PAIN/TMD? YES NO

If yes, by whom? _____ When: _____

6) Have you ever received treatment for jaw problems? YES NO

If yes, by whom? _____

Have you had injection therapy for your jaws in the past 3 months? YES NO

What was the treatment? (Please mark below)

Botox®, Myoblock®, Xeomin®, Dysport®, cortisone, other injectable anti-inflammatories

Medications: Flexeril, Soma, Baclofen, Diazepam, other _____

Bite Splint, Night Guard, Physical Therapy, Occlusal Adjustment, Orthodontics, Counseling, Surgery

Other (Please explain): _____

CURRENT MEDICATIONS/APPLIANCES:

1) Degree of current PAIN/TMD pain: 0 1 2 3 4 5 6 7 8 9 10

2) Frequency of PAIN/TMD pain: Daily Weekly Monthly Semi-Annually

Is there a pattern related to pain occurrence? Upon Waking Morning Afternoon Evening After Eating

3) Are you taking medication for the PAIN/TMD problem? YES NO

If so, what type? _____ Date started _____

Who prescribed the medication? _____

4) Are the medications that you take effective? YES NO Conditional

5) Are you aware of anything that makes your pain worse? YES NO

If yes, what? _____

6) Does your jaw make noise? YES NO

RIGHT Clicking Popping Grinding Other: _____

LEFT Clicking Popping Grinding Other: _____

7) Does your jaw lock open? YES NO When did this first occur? _____

How often? _____

8) Has your jaw ever locked closed or partly closed? YES NO

When did this first occur? _____ How often? _____

9) Have any dental appliances (splint, night guard, NTI) been prescribed? YES NO

If yes, by whom? _____ When? _____

Describe: _____

10) Are these appliances effective? YES NO

11) Is there any additional information that can help us in this area? _____

CURRENT STRESS FACTORS: (Please mark each factor that applies to you)

Death of Spouse	Major Illness or Injury	Major Health Change in Family
Business Adjustment	Divorce	Pending Marriage
Financial Problems	Pregnancy	Career Change
Fired from Work	Marital Reconciliation	Taking on Debt
Death of Family Member	New Person Joins Family	Other
Marital Separation		

HABIT HISTORY: (Please mark your answer to each question)

1) Do you clench your teeth together under stress? YES NO DON'T KNOW

2) Do you grind/clench your teeth at night? YES NO DON'T KNOW

3) Do you sleep with an unusual head position? YES NO DON'T KNOW

4) Are you aware of any habits or activities that may aggravate this condition? YES NO DON'T KNOW

Describe: _____

SYMPTOMS: (Please mark each symptom that applies)

A. HEAD PAIN, HEADACHES, FACIAL PAIN
Forehead L R
Temples L R
Migraine Type Headaches
Cluster Headaches
Maxillary Sinus Headaches (under the eyes)
Occipital Headaches (back of the head), shooting pain
Hair and/or Scalp Painful to Touch
Jaw Locking Opened or Closed

B. EYE PAIN OR ORBITAL PROBLEMS
Eye Pain – Above, Below or Behind
Bloodshot Eyes
Blurring of vision
Bulging Appearance
Pressure Behind the Eyes
Light Sensitivity
Watering of the Eyes
Drooping of the Eyelids

C. MOUTH, FACE, CHEEK, CHIN PROBLEMS
Pain in the Hard Palate
Pain in Cheek Muscles

D. TEETH AND GUM PROBLEMS
Clenching, Grinding at Night
Looseness and/or Soreness of Back Teeth
Tooth Pain

E. JAW & JAW JOINT (PAIN/TMD) PROBLEMS
Clicking, Popping Jaw Joints
Grating Sounds
Uncontrollable Jaw/Tongue movements
Limited Opening
Inability to Open Smoothly

F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES
Hissing, Buzzing, Ringing, or Roaring Sounds
Ear Pain without Infection
Clogged, Stuffy, Itchy Ears
Diminished Hearing
Balance Problems – "Vertigo"

G. THROAT PROBLEMS
Swallowing Difficulties
Tightness of Throat
Sore Throat
Voice Fluctuations
Laryngitis
Frequent Coughing/Clearing Throat
Feeling of Foreign Object in Throat
Tongue Pain
Salivation

H. NECK AND SHOULDER PAIN
Reduced Neck Mobility and Range of motion
Stiffness
Neck Pain
Tired, Sore Neck Muscles
Back Pain, Upper and Lower
Shoulder Aches

Arm or Finger Tingling or Numbness

I. OTHER PAIN
If so, please describe: _____

HEADACHE HISTORY QUESTIONAIRE

1. On a scale of 1-10, with "10" being the worst pain imaginable (above the shoulders), what's the average pain "number" you usually wake with? _____
2. How many mornings per week do you wake with "0" (zero) pain? _____
3. What % of your waking time do you have some degree of headache? _____%
4. What % of time do you awaken with "0" (zero) pain when not taking medications? _____%
5. What is your average headache pain level (1-10 scale) throughout the day? ____
6. What time of day do you usually experience your worst headaches? _____
7. On a scale of 1-10, what is the worst pain level you experience? _____
8. How many times per week (or month) might you experience your worst pain? ___
9. From where does that pain seem to originate? _____
10. How would you describe your pain? (examples: throbbing, squeezing, pressure, dull, stabbing, shooting, etc.) _____
11. Do you have pain in eyes, or is vision affected while having this pain? _____
12. Please circle the types of health care providers you've seen for your headaches: MD, Neurologist, ENT, Internist, Physical Therapist, Chiropractor, Dentist, Others
13. What medical tests have been performed regarding your headaches? CT scan, MRI, X-ray, Blood analysis, Other: _____
14. What types of procedures or treatments (including dental) have you had regarding your headaches? _____
15. What medication(s) do you *now* take to *prevent* your headaches? _____
16. What medications have you *tried before* to *prevent* your headaches? _____
17. What prescription or over-the-counter medications do you take to *relieve* your headaches, and how much? _____

I am aware that most treatments using Botox® for pain are off-label, including these treatments.
I am also aware and accept that that most common side-effects of these treatments includes headaches, bruising, and droopy eyes and mouth.
I am also aware that the treatment may not work.
I have elected to accept this treatment, despite the side-effects.

Off label & informed consent signed

BY PATIENT: _____

Date: _____

DENTOX POST OP INSTRUCTIONS
AFTER BOTOX INJECTIONS

1. **Dressing:** No dressings are required following Botox treatment. Do not apply an icepack or massage the injection sites. Any remaining dry bloodspots should be gently wiped off with ice water on a cotton swab in sweeping motions away from your eye.

2. **Position**: Try to sleep on your back the first night following Botox treatment so that you avoid compressing the facial areas injected with Botox. Similarly, avoid pressing over the areas treated with Botox immediately after treatment. Compression of any sort, will result in the Botox migrating from the area injected, and consequently, not acting on the desired muscle. Also, avoid lying down until bedtime the day of Botox injection.

3. **Activity**: You may return to routine daily activity or your job immediately following Botox treatment. However, you must avoid exercising for 24 hours. This is because exercise will increase the blood flow to the facial region which may then draw the Botox out and into circulation; this will result in less effective relaxation of the targeted muscles

4. **Driving**: You may drive immediately following Botox treatments.

5. **Ice Packs**: Icing is not recommended as this will result in unnecessary compression of the areas treated.

6. **Exposure to sunlight**: You may expose yourself to limited sunlight immediately following treatment.

7. **Final Appearance**: You will notice drastic improvement in facial muscles as early as 36 hours following Botox treatment. Maximum effects will be observed at 12 days following Botox injection.

9. **Postoperative follow-up:** In general, you do not need to follow up with your doctor following Botox treatment unless there is severe asymmetry. With asymmetry return for a follow up visit after 2 weeks. You should expect to return to your doctor for repeat treatments every 3 to 6 months.