Cascade Oral Medicine Inc., P.S.

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Patient Health History

Date:

Thank you for entrusting us with you care. *Please complete and return this questionnaire prior to your appointment.* This will help ensure our best care for you and help us understand all aspects of your health. Please answer these questions as accurately as possible. All of your information in your medical record is private and will be held confidential.

General Information			
Last Name	First Name	Middle	Birthdate
Gender identity:	Referring Doctor:	Doctor(s) you would like to be informed of your care:	

Chief Concern

Please describe your problem:

Circle any words which describe your problem:

Numbness	*Swelling*	*Nausea*	*Too much / little saliva*
Lump or growth	*Ulcers*	*Pain*	*Altered consistency saliva*
Redness	*Blisters*	- *Sharp*	*Reduced or metallic taste*
Inflammation	*Yeast Infections*	- *Dull*	*Bad taste in mouth*
Infection	*Bleeding gums*	- *Throbbing*	*Strange / bad smell*
Burning tongue / mouth	*Bad breath*	- *Electric*	*Reduced / Increased Smell*

Who detected the problem?	**What aggravates your problem?**
How long have you had the problem?	**What alleviates symptoms?**
Is your problem better, worse or the same since it started?	**How often does your pain appear?** *(please circle)* Constant Several times a day Daily Weekly Monthly

The onset of your problem was: *(please circle)*
Sudden Gradual Triggered by: Other:

Was the onset of your symptoms related to any of the following? *(please circle)*

- *Endocrine Disease*
- *Autoimmune Disease*
- *Nerve Disease*
- *Gastrointestinal Disease*
- *Cancer treatment*
- *Flu or Cold*
- *Hormonal Changes*
- *Stress*
- *Depression*
- *Anxiety*
- *Medication reaction*
- *Radiation therapy*
- *Surgery of ear nose or throat*
- *Recent dental treatment*
- *Work-related incident*
- *Environment-related incident*
- *Head trauma: Car accident, assault, accidental, combat*
- *Saliva gland injury/ pain while or after eating*

Do you have a history of any of the following? *(please circle)*

- *Salivary gland infections*
- *Salivary tumor or Cyst*
- *Salivary gland obstruction*
- *Salivary gland surgery*
- *Radiation of Saliva Glands*

Do you have any of the following problems? *(please circle)*

- *Difficulty chewing dry food*
- *Need water or liquid to help swallow*
- *Pain with swallowing*
- *Reflux problems*

If you have or have had pain, please answer this section. If not, please skip to the next section(s).

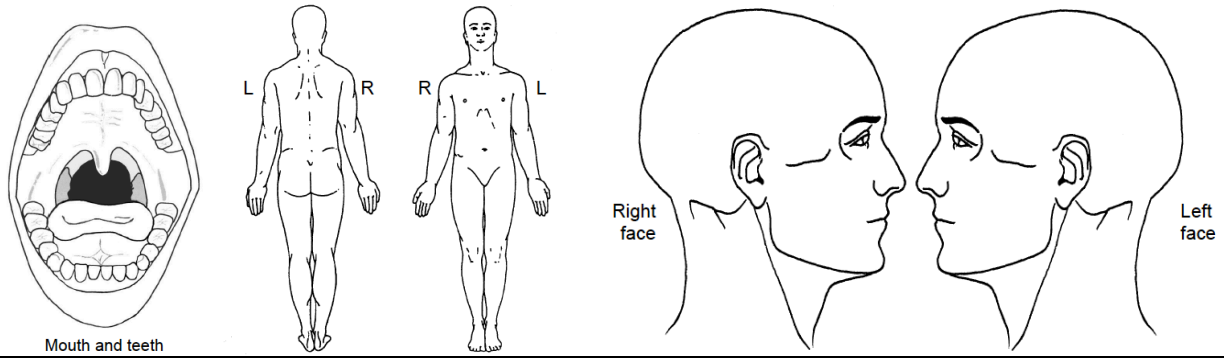
What does your pain feel like? (ex: burning, numbness, aching, radiating, blinding, agonizing, etc)

Is your pain better, worse, or the same since it started?

How often does your pain appear?

Constant Several times a day Daily Weekly Monthly

Please circle the location(s) of your pain:



Pain Description:

On how many days in the last 6 months have you had facial pain? _____Days

Using a scale from 0-10, where 0 is "no pain" and 10 is "pain as bad as could be," please rate your facial pain:

____/10 How would you rate your facial pain right now?
____/10 In the last 30 days, how would you rate your worst pain?
____/10 On average, how would you rate your facial pain?
____/10 In the last 30 days, how many days did your facial pain keep you from doing your usual activities (work, school)?

Using a scale from 0-10, where 0 is "no interference" and 10 is "unable to carry on any activities."

____/10 In the last 30 days, how much has facial pain interfered with your daily activities?
____/10 In the last 30 days, how much has facial pain interfered with your recreational, social, and family activities?
____/10 In the last 30 days, how much has facial pain interfered with your ability to work including housework?

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than 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
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Tests and Treatments

Please List any tests, x-rays, biopsy, or other procedures you have had for your overall problem

Date	Test	Doctor	Result
1. 2. 3. 4. 5.			

Please list any treatments you have received and how successful the treatment was (include medications and physical therapy):

Date	Test	Doctor	Result
1. 2. 3. 4. 5.			

What other symptoms do you have?

General
- ○ Weight loss
- ○ Weight gain
- ○ Loss of appetite
- ○ Always hungry
- ○ Always thirsty
- ○ Frequent urination
- ○ Tend to feel hot
- ○ Tend to feel cold
- ○ Fatigue
- ○ Faint easily
- ○ Bruise Easily

Behavioral
- ○ Anger
- ○ Worry
- ○ Sleep problems
- ○ Reduced Social Activities
- ○ Problems at work/school
- ○ Suicidal thoughts

Eyes
- ○ Vision changes
- ○ Eye itching
- ○ Dry eyes
- ○ Eye pain

Ears
- ○ Hearing loss
- ○ Ringing ears
- ○ Earaches
- ○ Dizziness
- ○ Pressure/stuffy ears

Nose/Throat
- ○ Congested/runny nose
- ○ Nose bleeds
- ○ Nasal obstruction
- ○ Sore throat
- ○ Hoarse voice
- ○ Mouth breathing/snore

Head and Neck
- ○ Neck pain
- ○ Neck lump/swelling
- ○ Headache
- ○ Facial pain
- ○ Migraine

Musculoskeletal
- ○ Joint pain
- ○ Swollen joints
- ○ Muscle cramping
- ○ Arm/hand weakness

Gastrointestinal
- ○ Indigestion
- ○ Reflux/heartburn
- ○ Nausea/vomiting
- ○ Constipation
- ○ Diarrhea

Skin Changes
- ○ Color changes
- ○ Itching/burning
- ○ Nail changes
- ○ Other skin problems

Cardiovascular
- ○ Shortness of breath w/ exertion
- ○ Racing heart beat
- ○ Swollen ankles
- ○ Cold ankles/feet
- ○ Chest pain/angina

Respiratory
- ○ Coughing spells
- ○ Coughing up phlegm
- ○ Wheezing
- ○ Frequent colds
- ○ Use >2 pillows to sleep

Neurological
- ○ Loss of muscle control
- ○ Trembling
- ○ Numbness/tingling
- ○ Paralysis
- ○ Handwriting changes
- ○ Memory changes
- ○ Neuropathy

Females Only
- ○ Irregular periods
- ○ Regular periods
- ○ Menstrual pains
- ○ Peri-menopause
- ○ Post-menopause
- ○ Pregnant (mo:)
- ○ Vaginal itching
- ○ Vaginal dryness
- ○ Recurrent vaginal yeast infections
- ○ Vaginal ulcers
- ○ Use birth control pills
- ○ Receive Depo-Provera injections
- ○ Hormone Therapy
- ○ Hysterectomy (Age:)
- ○ Had ovary(ies) removed (Age:)

Medical history: please check the appropriate column for illnesses that you have now or had in the past or family had/has:

Now	Past	Fam	Illness	Now	Past	Fam	Illness	Now	Past	Fam	Illness
			Cancer:				Injury to face/jaw/neck				Kidney disease
			Genetic disease				Fractures				Bladder disease
			Leukemia				Concussion				Urethritis
			Lymphoma				Osteoarthritis				Liver disease
			Organ transplant				Headache				Rheumatic fever
			Rheumatoid arthritis				Migraine				Scarlet fever
			Osteoarthritis				Back pain				Polio
			Lupus erythematosus				Abdominal pain				Strep throat
			Sjogren's Syndrome				Herpes zoster				Mononucleosis
			Other immune disease				Fungal infections				Hepatitis
			Diabetes				Other skin disease				Venereal disease
			Thyroid Problems				Gastric ulcer				Genital/anal warts
			Hormone Disorder				Colitis				Genital herpes
			High Blood Pressure				Pancreatitis				Psychiatric illness
			Arteriosclerosis				Gastritis				Anxiety/panic attacks
			Heart attack/MI				Crohn's disease				Depression
			Angina/chest pain				Celiac Sprue				Suicide attempt or thoughts
			Heart murmur				Gall bladder problems				Physical/Sexual/Emotional Abuse
			Heart valve problems				Splenectomy				Drug abuse
			Other heart disease				Irritable bowel syndrome				Alcohol absue
			Bleeding disorder				Emphysema				Prosthetic valve/joint
			Anemia				Pneumonia				Require antibiotic medication
			Epilepsy/seizures				Bronchitis				Head and neck radiation therapy
			Neuralgia				Sinusitis				Contact lenses
			Stroke				Hayfever				HIV Infection
			Bell's Palsy				Asthma				AIDS
			Other nerve problems				Tuberculosis				Bisphosphonate Use
			Glaucoma				Other:				Other:

○ **I have never had any of the above conditions**

○ **There are questions in this section that I did not understand**

Major Hospitalizations, Surgeries, and Blood Transfusions

○ **Mark here if none**

Date	Procedure	Reason

Allergic or Unusual Reaction to any of the Following?			○ **Mark here if none**
○ Penicillin ○ Sulfa ○ Iodine ○ Latex	○ Aspirin ○ Opiates/codeine ○ Local anesthesia	Other medication(s):	Other allergies (food, metals, etc.):

Were you exposed to any of the following hazards at home, work, or due to your hobbies?			
○ Biological hazards ○ Chemical Hazards ○ Heavy Metals (lead, mercury)	○ Asbestos ○ Fumes ○ Radiation	○ Dust ○ Exessive Noise ○ Extreme temperatures	○ Others:

Medications (please attach an additional sheet if needed)				○ **Mark here if none**
Prescription **Medication Name**	**Dose**	**Taken for:**	**Rx by:**	**Length of time taken**
1.				____wks ____mos ____ yrs
2.				____wks ____mos ____ yrs
3.				____wks ____mos ____ yrs
4.				____wks ____mos ____ yrs
5.				____wks ____mos ____ yrs
Over-the-Counter **Medication Name**	**Dose**	**Taken for:**	**Rx by:**	**Length of time taken**
1.				____wks ____mos ____ yrs
2.				____wks ____mos ____ yrs
3.				____wks ____mos ____ yrs
4.				____wks ____mos ____ yrs
5.				____wks ____mos ____ yrs

General Health Rating	
Your health in general is: Excellent Very Good Fair Poor	Your oral health is: Excellent Very Good Fair Poor
How good a job do you feel you are doing in your overall health? Excellent Very Good Fair Poor	How good a job do you feel you are doing in your dental health? Excellent Very Good Fair Poor
Date of last physical exam:	Date of last dental checkup:
Do you engage in regular exercise? Yes or No If so, what type?	

Consumption of Beverages and Other Substances										○ **Mark here if none**	
Average # of caffeinated drinks/day					**Average # alcoholic drinks/day/wk**						
Please circle										**Tobacco Products**	**Recreational Drugs**
Coffee	0	1-2	3-5	>5	Beer	0	1-2	3-5	6-10	>10	Have you ever used tobacco?	Do you use any street or recreation drugs? Y N
Tea	0	1-2	3-5	>5	Wine	0	1-2	3-5	6-10	>10	If yes, what type? Cigarettes pipe/cigar smokeless Average # uses/day:	Do you use any prescription drugs that are not prescribed for you? Y N
Soda	0	1-2	3-5	>5	Spirits	0	1-2	3-5	6-10	>10	Current use? Y/N Years used: Interested in quitting? Y N	

Dental History			
Please check all that applies to your dental history:		**Oral Hygiene Habits**	**Oral Care Products**
○ Regular dental care ○ Emergency treatment only ○ Occasional dental care ○ Orthodontics ○ Wisdom tooth extractions ○ Gum disease (gingivitis, periodontitis) ○ Geographic tongue ○ Thrush ○ Cold sores or fever blisters ○ Oral Lichen Planus	○ Dentures ○ Treatment for Jaw Trauma /Fracture ○ Root canals ○ Cavities ○ Orthognathic surgery ○ Periodontal surgery ○ Other oral surgery ○ Bite adjustment ○ Night guard ○ TMJ problems	<u>Toothbrush use/day:</u> ○ Never ○ Sometimes ○ 1/day ○ ≥2/day <u>Floss /day</u> ○ Never ○ Sometimes ○ 1/day ○ ≥2/day	Name of toothpaste: Name of mouthwash/or fluoride rinse: Denture cleanser:

Thank you for taking the time to complete this history.
Your thoroughness is appreciated and will help us better attend to your concerns.