

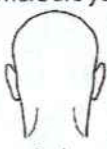



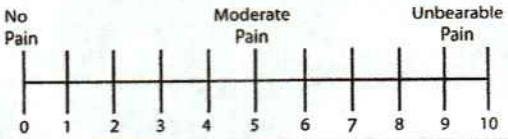
PAIN/HEADACHE HISTORY

Copyright © 2014 Dental Resource Systems, Inc. All Rights Reserved. Rev 1215148

PATIENT INFORMATION

NAME	DATE TODAY / /	AGE	SEX	TELEPHONE
------	-------------------	-----	-----	-----------

Please review and answer all parts of each question with our staff. Provide specific details/notes in the right hand column.

#	QUESTIONS																																													
1	<p>Have you been diagnosed by a health care provider with any of the following?</p> <p>» <input type="checkbox"/> Migraine » <input type="checkbox"/> Chronic Daily Headache » <input type="checkbox"/> Tension Headache » <input type="checkbox"/> Cluster Headache » <input type="checkbox"/> Medication Overuse Headache</p> <p>» <input type="checkbox"/> Menstrual Migraine » <input type="checkbox"/> Trigeminal Neuralgia » <input type="checkbox"/> Fibromyalgia » <input type="checkbox"/> TMJ/D » <input type="checkbox"/> Neck Problems » <input type="checkbox"/> Other _____</p>																																													
2	<p>What sets off or triggers your pain or headaches?</p> <p>_____</p>																																													
3	<p>What tests have you had to help diagnose your headaches?</p> <p>» <input type="checkbox"/> MRI » <input type="checkbox"/> CT Scan » <input type="checkbox"/> Blood Tests » <input type="checkbox"/> Hormone Testing</p>																																													
4	<p>Where are your pain/headaches located? (Mark Locations)</p> <div style="display: flex; justify-content: space-around;">     </div> <p>On a scale of 1-10, how painful is it?</p> <div style="display: flex; align-items: center;"> <div style="margin-right: 10px;">No Pain</div>  <div style="margin-left: 10px;">Unbearable Pain</div> </div>																																													
5	<p>Describe the type of headache pain you feel most often:</p> <p>» <input type="checkbox"/> Achy » <input type="checkbox"/> Throbbing » <input type="checkbox"/> Stabbing » <input type="checkbox"/> Other _____</p>																																													
6	<p>What other doctors have you seen for your pain, headaches, and/or migraines</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> GP / FAMILY DOCTOR / OB-GYN <input type="checkbox"/> DENTIST (IF OTHER) <input type="checkbox"/> NEUROLOGIST <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> PHYSICAL THERAPIST <input type="checkbox"/> CHIROPRACTOR <input type="checkbox"/> EAR NOSE THROAT <input type="checkbox"/> OTHER </td> </tr> </table>	<input type="checkbox"/> GP / FAMILY DOCTOR / OB-GYN <input type="checkbox"/> DENTIST (IF OTHER) <input type="checkbox"/> NEUROLOGIST <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST	<input type="checkbox"/> PHYSICAL THERAPIST <input type="checkbox"/> CHIROPRACTOR <input type="checkbox"/> EAR NOSE THROAT <input type="checkbox"/> OTHER																																											
<input type="checkbox"/> GP / FAMILY DOCTOR / OB-GYN <input type="checkbox"/> DENTIST (IF OTHER) <input type="checkbox"/> NEUROLOGIST <input type="checkbox"/> PSYCHIATRIST/PSYCHOLOGIST	<input type="checkbox"/> PHYSICAL THERAPIST <input type="checkbox"/> CHIROPRACTOR <input type="checkbox"/> EAR NOSE THROAT <input type="checkbox"/> OTHER																																													
7	<p>What medications do you use for headache, migraine, or pain relief?</p> <table border="1" style="width: 100%;"> <thead> <tr> <th>MEDICATION (NAME OF MEDICATION OR SUBSTANCE)</th> <th>WHAT DOSE?</th> <th>HOW OFTEN?</th> </tr> </thead> <tbody> <tr><td>Acetaminophen, Tylenol</td><td></td><td></td></tr> <tr><td>Ibuprofen, Advil, Motrin, Nuprin, etc..</td><td></td><td></td></tr> <tr><td>Naproxin, Aleve</td><td></td><td></td></tr> <tr><td>Rx pain medication ()</td><td></td><td></td></tr> <tr><td>Rx pain medication ()</td><td></td><td></td></tr> <tr><td>Rx muscle relaxant ()</td><td></td><td></td></tr> <tr><td>Rx anxiety medication ()</td><td></td><td></td></tr> <tr><td>Rx depression medication ()</td><td></td><td></td></tr> <tr><td>Rx migraine medication ()</td><td></td><td></td></tr> <tr><td>Medication for sleeping ()</td><td></td><td></td></tr> <tr><td>Caffeine intake ()</td><td></td><td></td></tr> <tr><td>Alcohol intake ()</td><td></td><td></td></tr> <tr><td>THC, Medical Marijuana ()</td><td></td><td></td></tr> <tr><td>Other: ()</td><td></td><td></td></tr> </tbody> </table>	MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?	Acetaminophen, Tylenol			Ibuprofen, Advil, Motrin, Nuprin, etc..			Naproxin, Aleve			Rx pain medication ()			Rx pain medication ()			Rx muscle relaxant ()			Rx anxiety medication ()			Rx depression medication ()			Rx migraine medication ()			Medication for sleeping ()			Caffeine intake ()			Alcohol intake ()			THC, Medical Marijuana ()			Other: ()		
MEDICATION (NAME OF MEDICATION OR SUBSTANCE)	WHAT DOSE?	HOW OFTEN?																																												
Acetaminophen, Tylenol																																														
Ibuprofen, Advil, Motrin, Nuprin, etc..																																														
Naproxin, Aleve																																														
Rx pain medication ()																																														
Rx pain medication ()																																														
Rx muscle relaxant ()																																														
Rx anxiety medication ()																																														
Rx depression medication ()																																														
Rx migraine medication ()																																														
Medication for sleeping ()																																														
Caffeine intake ()																																														
Alcohol intake ()																																														
THC, Medical Marijuana ()																																														
Other: ()																																														
8	<p>Do you try non-medicating techniques for managing your pain or headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>» <input type="checkbox"/> Yoga » <input type="checkbox"/> Breathing Exercises » <input type="checkbox"/> Cold Packs » <input type="checkbox"/> Massage » <input type="checkbox"/> Meditation » <input type="checkbox"/> Physical Therapy » <input type="checkbox"/> Hot Packs/ Hot Bath</p> <p>» <input type="checkbox"/> Acupuncture » <input type="checkbox"/> Exercise » <input type="checkbox"/> Other (please describe) _____</p>																																													

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION BEST DESCRIBES THE TREATMENTS AND MEDICATIONS I HAVE USED TO HELP ALLEVIATE MY HEADACHES/MIGRAINES/PAIN.

PATIENT SIGNATURE _____