P

PERTH ORAL MEDICINE & DENTAL SLEEP CENTRE

Title Dr Mr Mrs Ms Miss (Please tick) **Known As** _____

First Name _____ **Surname** _____ **Marital Status** _____

Date of Birth _____ / _____ / _____ **Occupation** _____

Home Address _____

Suburb _____ P/code _____

Postal Address _____

Suburb _____ P/code _____

Telephone (M) _____ (H) _____

Email Address _____

Work Details _____ (W) _____

Emergency Contact/ Next of Kin Name _____ Relationship _____

(M) _____ (H) _____

Medicare No _____ Ref _____ Exp _____ / _____

HCC/Pensioner _____ Exp _____ / _____

Department of Veteran Affairs _____ Colour _____ Exp _____ / _____

Private Health **YES / NO** **Insurer Name** _____

Is this for **Workers' Compensation** ☐ or **Motor Vehicle Accident** ☐? (Please See Reception)

General Practitioner _____ (W) _____

Address _____

Dentist _____ (W) _____

Address _____

Referred by ☐ General Practitioner ☐ Dentist ☐ Other (Details below)

Name _____ (W) _____

Address _____

For additional health practitioners involved in your care, please complete their details below.

Name of Practitioner _____ Specialty_____

Address _____

Name of Practitioner _____ Specialty_____

Address _____

***Privacy Statement**: We value your privacy. All of the information, which you provide to us, will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is available from our Reception staff. Please speak to one of our staff members if you have any concerns about how we will use your personal information.*

1. Please answer the following questionnaire truthfully and to the best of your ability. If ever your health status or medications change, please inform your practitioner at the next appointment.
2. Practice policy is all accounts are settled on the day, immediately after seeing the practitioner.
3. Please note that Medicare rebates are not available. Rebate for services are only available from Private Health Funds. We do not process Private Health Fund rebates for patients at the rooms.
4. The practitioners are not "preferred providers" of any Private Health Fund and have no control over your rebate received.
5. Patients will be charged for missed and late cancellation appointments unless cancelled 24 hours prior to the consult time. DVA, Workers' Compensation and Motor Vehicle Accident patients will be charged privately for appointments not kept.
6. Some consultations and procedures may not be claimable under Workers' Compensation, Third Party or General Insurance. We will assist you in directing your bills to the relevant insurance body/solicitors for settlement. However, you are ultimately responsible for the account irrespective of any disputes with the insurance companies.
7. Please ensure the above information regarding health practitioners involved in your care is current and complete. Correspondence will be sent to all health practitioners listed unless you advise us otherwise.
8. We would appreciate notification of any change of address.
9. CCTV (video only) operates in these premises for security reasons only and not for patient records.
10. I consent to allow my de-identified clinical information and photographs to be used for educational purposes.

I declare that the particulars and information provided are true and correct, and I understand and agree to the above conditions. Further, I hereby authorise **Perth Oral Medicine & Dental Sleep Centre** and its practitioners, to obtain and release information about my condition to assist in my treatment and/or rehabilitation.

Patient/Guardian Signature _____ Date _____ / _____ / _____

(If under 18 years): Guardian Name _____

Guardian Address _____ Phone _____

Do you have a **Trust Account** or a **Third Party** that settles your account? If yes, please see Reception.

Please Tick	**Yes**	**No**	**Details**
Do you smoke? *If so, how many per day, and for how many years?*			
Are you a past smoker? *If so, how many did you smoke and for how many years? When did you stop smoking?*			
Do you drink alcohol on a regular basis? If so, how many per day, and for how many years?			
Do you drink coffee, tea or cola? *If yes, how much?*			
Do you or have you used recreational drugs? *If so, please specify*.			
Are you taking any tablets or medicines (prescribed or over-the-counter preparations) at present? *If yes, please specify*.			
Do you have any known allergies (penicillin, drugs, latex, and foods)? *If yes, please specify*.			
Do you have any dental treatment that is ongoing? *If yes, please specify*.			
When was your last appointment with a dentist?			

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please tick)								
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Neck pain			Teeth pain			Sleep disorders		
Headache or migraine			Teeth clenching or grinding			Obsessive compulsive disorder		
Arthritis			Jaw surgery			Depression		
Sinus problems			Fibromyalgia			Anxiety		
Chronic pain			Irritable bowel syndrome			Post-traumatic stress disorder		
Currently pregnant								
Do you have any other medical conditions? *If yes, please list all other medical conditions.*								

1. When did your jaw, head or oral pain start?

2. List in order of importance all of the problems or symptoms which trouble you. Describe them briefly.

3. What do you think is the cause of your pain?

4. Rate how much pain you are experiencing now by ticking a number on the line below:

0 1 2 3 4 5 6 7 8 9 10

No pain Mild pain Moderate pain Severe pain Most intense pain

5. Have you had a jaw, head or neck injury that could have caused your pain/problem?

☐ Yes ☐ No

If yes, please list the date of the injury(s) and describe.

If yes, please tick a number to indicate how much your jaw, head or neck injury contributes to the cause of your pain/problem?

0 1 2 3 4 5 6 7 8 9 10

No contribution Some contribution Only cause

6. Have you received any prior treatment or evaluation for this problem? Describe briefly.

7. Rate how much your pain has interfered with activities over the last 5 days by circling a number on the line below:

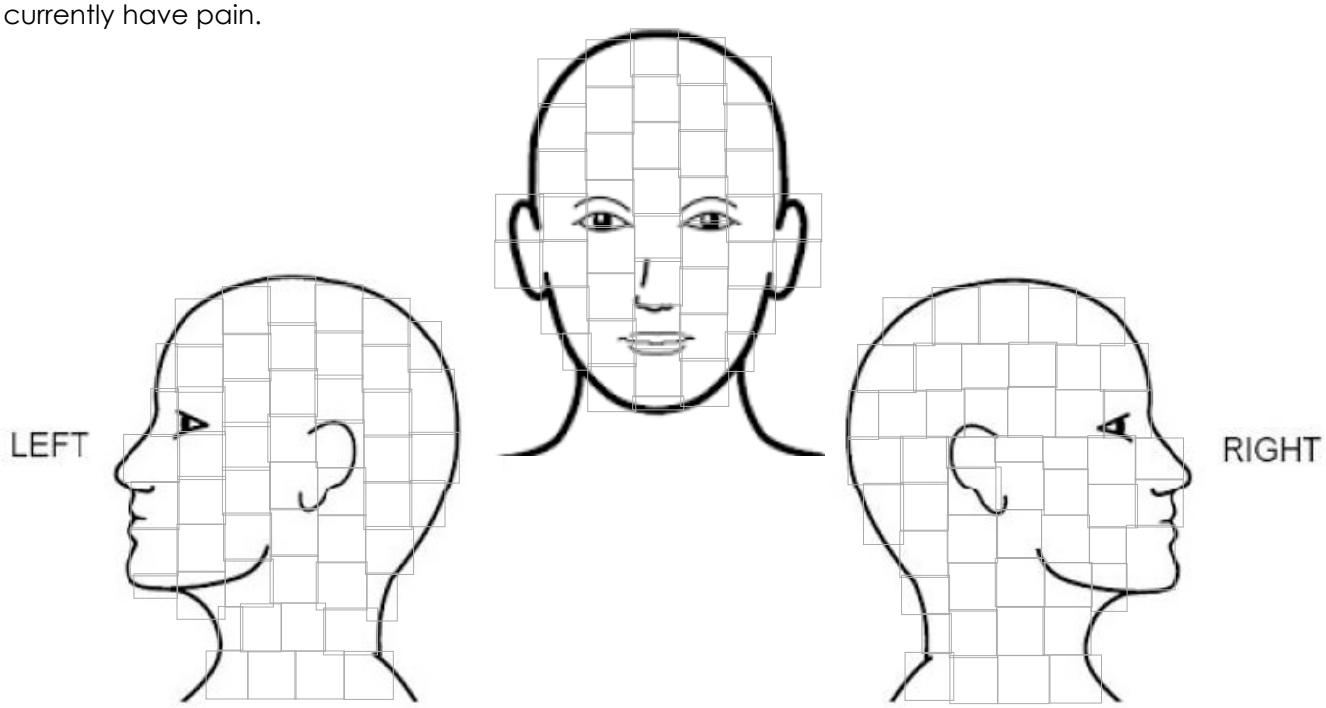
0 1 2 3 4 5 6 7 8 9 10

No interference — Unable to complete any activities

8. Rate the usual intensity of your pain throughout the day by circling a number that best represents your pain:

	No pain			Mild pain			Moderate pain			Severe pain			Most intense pain
Morning	0	1	2	3	4	5	6	7	8	9	10		
Noon	0	1	2	3	4	5	6	7	8	9	10		
Afternoon	0	1	2	3	4	5	6	7	8	9	10		
Evening	0	1	2	3	4	5	6	7	8	9	10		
Sleep	0	1	2	3	4	5	6	7	8	9	10		

9. On the diagram below, please mark those areas in both the head and neck where you currently have pain.



10. Please tick the appropriate boxes for the following questions.

Jaw Pain:	Does Not Hurt At All	Hurts A Little	Hurts A Lot	Almost Unbearable	Unbearable Pain Without Relief
1. Does it hurt when you open your mouth wide or yawn?					
2. Does it hurt when you chew or use your jaw?					
3. Does it hurt when you are not chewing or using your jaw?					
4. Is your pain worse on waking?					
5. Do you have pain in front of your ears or an ear ache?					
6. Do you have jaw muscle (cheek) pain?					
7. Do you have pain in your temples?					
8. Do you have pain or soreness in your teeth?					

Jaw Function:	No	Maybe A Little	Quite A Lot	Almost All The Time	All The Time Without Stopping
1. Does your jaw joint make a noise that bothers you or others?					
2. Do you find it difficult to open your mouth wide?					
3. Does your jaw ever lock closed so you cannot open it?					
4. Does your jaw ever lock open so you cannot close it?					
5. Do you have an uncomfortable bite?					

Jaw Habits:	No	Maybe A Little	Quite A Lot	Almost All The Time	All The Time Without Stopping
1. Do you clench or grind your teeth during the day?					
2. Do you clench or grind your teeth during sleep?					
3. Do you chew gum frequently?					
4. Do you bite your fingernails?					
5. Do you rest your chin on your palm?					
6. Do you participate in habits/activities involving your jaw? eg musical instruments.					

11. Some of the words below describe pain. Tick any words that describe your pain. However, you may **only check one word in each box**. You do not have to tick a word in every box.

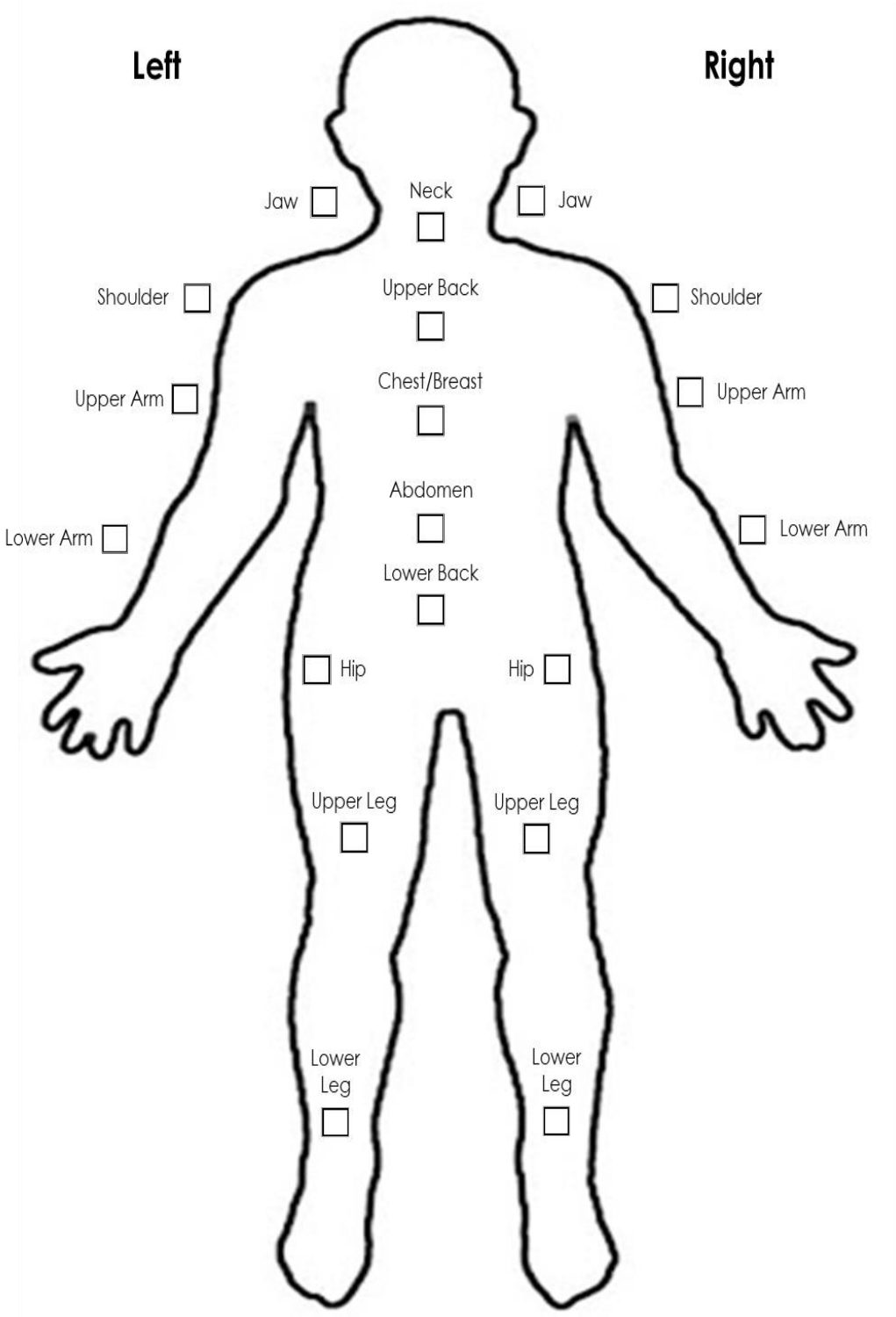
1 Flickering ☐ Quivering ☐ Pulsing ☐ Throbbing ☐ Beating ☐ Pounding ☐	2 Jumping ☐ Flashing ☐ Shooting ☐	3 Pricking ☐ Boring ☐ Drilling ☐ Stabbing ☐ Lancinating ☐	4 Sharp ☐ Cutting ☐ Lacerating ☐
5 Pinching ☐ Pressing ☐ Gnawing ☐ Cramping ☐ Crushing ☐	6 Tugging ☐ Pulling ☐ Wrenching ☐	7 Hot ☐ Burning ☐ Scalding ☐ Searing ☐	8 Tingling ☐ Itchy ☐ Smarting ☐ Stinging ☐
9 Dull ☐ Sore ☐ Hurting ☐ Aching ☐ Heavy ☐	10 Tender ☐ Taut ☐ Rasping ☐ Splitting ☐	11 Tiring ☐ Exhausting ☐	12 Sickening ☐ Suffocating ☐
13 Fearful ☐ Frightful ☐ Terrifying ☐	14 Punishing ☐ Gruelling ☐ Cruel ☐ Vicious ☐ Killing ☐	15 Wretched ☐ Blinding ☐	16 Annoying ☐ Troublesome ☐ Miserable ☐ Intense ☐ Unbearable ☐
17 Spreading ☐ Radiating ☐ Penetrating ☐ Piercing ☐	18 Tight ☐ Numb ☐ Drawing ☐ Squeezing ☐ Tearing ☐	19 Cool ☐ Cold ☐ Freezing ☐	20 Nagging ☐ Nauseating ☐ Agonising ☐ Dreadful ☐ Torturing ☐

12. Tick one word that best describes the pattern of your pain.

Continuous ☐ Steady ☐ Constant ☐	Varying ☐ Rhythmic ☐ Periodic ☐ Intermittent ☐	Brief ☐ Momentary ☐ Transient ☐

13. Fibromyalgia Symptoms (Modified ACR 2010 Fibromyalgia Diagnostic Criteria)

i. Please indicate below if you have had pain or tenderness over the <u>past 7 days</u> in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.



ii. Using the following scale, indicate for each item your severity over the past week by ticking the appropriate box.

- **No problem**
- **Slight or mild:** generally mild or intermittent
- **Moderate:** considerable problems; often present and/or at a moderate level
- **Severe:** continuous, life-disturbing problems

	No Problem	**Slight or Mild**	**Moderate**	**Severe**
a. Fatigue	☐	☐	☐	☐
b. Trouble thinking or remembering	☐	☐	☐	☐
c. Waking up tired (unrefreshed)	☐	☐	☐	☐

iii. During the past 6 months have you had any of the following symptoms?

	No	**Yes**
a. Pain or cramps in lower abdomen	☐	☐
b. Depression	☐	☐
c. Headache	☐	☐

iv. Have the symptoms in questions ii-iii and pain been present at a similar level for at least 3 months?

☐ **No** ☐ **Yes**

v. Do you have a disorder that would otherwise explain the pain?

☐ **No** ☐ **Yes**