Date: .....

1. Patient data

Last name:.....

First name: .....

Date of birth (dd-mm-yy): .....

Mobile phone number:.....

E-mail*:*

General practitioner:.....

Referred by:.....

2. Data on the facial pain

- Do you have more than one type of facial pain?

☐ No

☐ Yes: Briefly describe the different types below:

.....

.....

.....

For the rest of the questionnaire, describe the main facial pain.

a) Are you ever free of facial pain?

☐ No

☐ Yes. When, in what period?

☐ During pregnancy

☐ During holidays

☐ During weekends

☐ Arbitrary

☐ Other: .....

b) First facial pain:

Started…….ago. I was……years old.

c) What triggered your first facial pain?:

☐ I don't know.

☐ Dental care.

☐ Accident:.....

☐ Infection with fever

☐ Other:.....

d) Current pattern (how fast):

☐ Sudden ☐ Rapid ☐ Gradual ☐ Varies

Moment of the day::

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Awakens from sleep ☐ Varies

When is the facial pain more frequent:

☐ Weekends ☐ Weekdays ☐ Vacations
☐ Spring ☐ Summer ☐ Fall ☐ Winter

e) Type of pain

Before	Now	
☐	☐	Unpleasant sensation, hypersensitive area
☐	☐	Dull pain
☐	☐	Burning pain
☐	☐	Sharp pain
☐	☐	Electric shock
☐	☐	Boring pain
☐	☐	Stabbing pain

f) Intensity (circle)

Continuous pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

Bursts of pain 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10

- Are there fluctuations in intensity?
  - ☐ No
  - ☐ Yes, when?
    - ☐ At the beginning of the complaints
    - ☐ When the pain was most intense
    - ☐ Now

g) Temporal aspects

- Briefly describe the evolution of the pain over time (since the beginning of the complaints): .....
.....
.....
.....

- Duration of continuous pain:

…. Days …. Hours

- Durations of short bursts of pain:

…. Hours …. Minutes …. Seconds

h) Location (indicate on the drawing where the pain is located)

If the pain occurs in a specific nerve area, indicate on figure 1 or according to a subdivision of the trigeminal nerve, indicate on figure 2. If this is not the case, you can indicate the localization on page 7 on figure 3 if it is probably a muscle pain, on figure 4 if the pain emanates from a specific tooth, or if none of these is the case on figure 5.

Fig. 1a
LEFT:

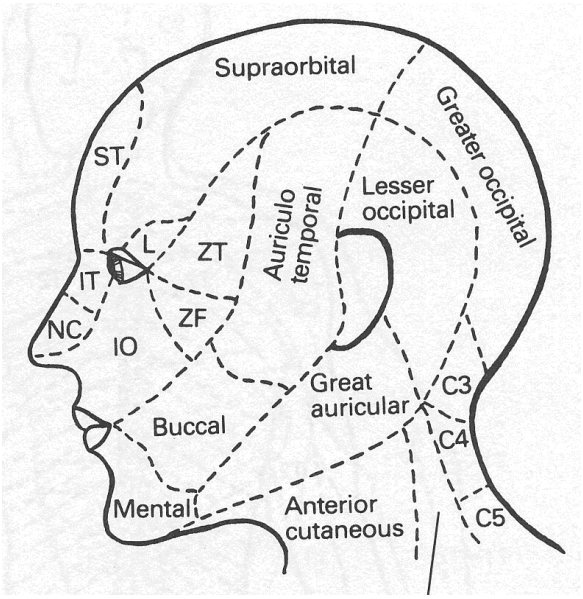


Fig. 2a

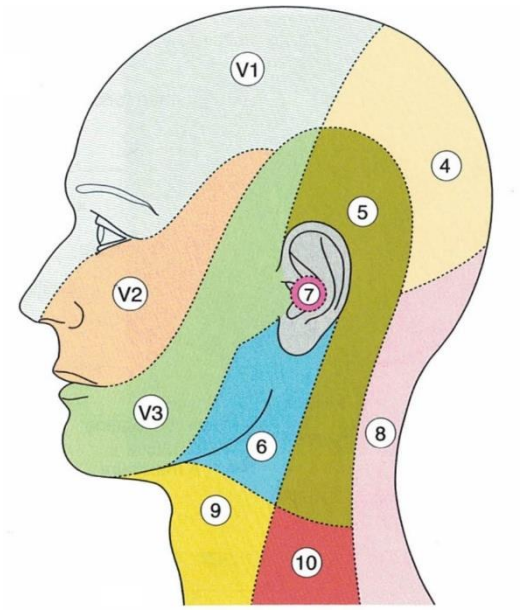


Fig. 1b
RIGHT:

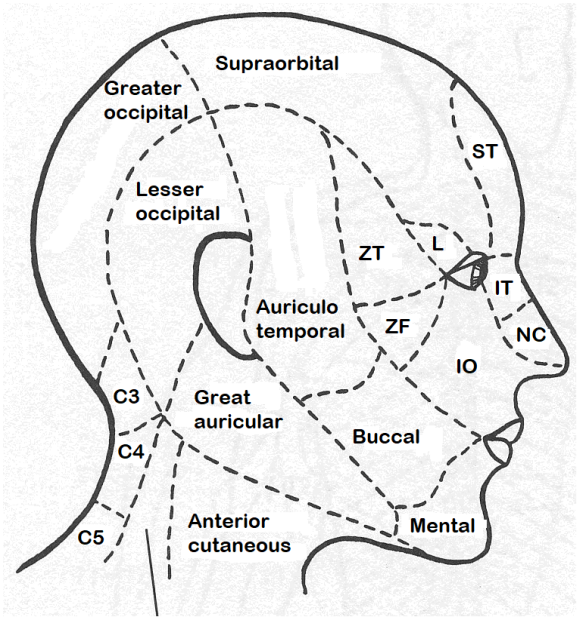
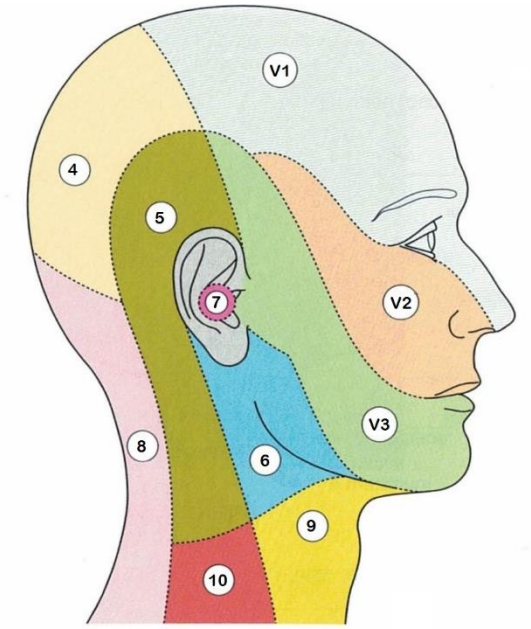


Fig. 2b



i) Character of continuous pain:

☐ Throbbing/ pulsing
☐ Achy
☐ Dull
☐ Other: ……
☐ Pressure
☐ Burning
☐ Stabbing

j) Character of short bursts of pain:

☐ Throbbing/ pulsing
☐ Burning
☐ Searing
☐ Shooting
☐ Stabbing
☐ Other: ……

k) Associated symptoms

☐ Vision problems
☐ Double vision
☐ Eye-tearing (R-L)
☐ Drooping eyelid (R-L)
☐ Dripping nose
☐ Stuffy nose

l) Influencing factors
Which of the following factors can aggravate or cause pain?

☐ Movement or contact in the facial area
☐ Jaw movements
☐ Tongue movements
☐ Swallow
☐ Speak
☐ A certain position of the head
☐ A certain body position
☐ Physical activities/exertion
☐ Stress, tension
☐ Menstruation
☐ Fatigue

3. Quality of life:

My appetite lately is: ☐ Increased ☐ Decreased ☐ not changed
My mood lately is: ☐ better ☐ worse ☐ not changed

My psychical condition can be described as:
☐ anxious ☐ calm ☐ euphoric
☐ irritable ☐ depressed

I get ..... hours of sleep per night.
Difficulties falling asleep : ☐ Yes ☐ No
I wake up during the night or early morning due to my headache:
☐ Yes ☐ No

I wake up with headache: ☐ Yes ☐ No
Sexual difficulties: ☐ Yes ☐ No

Effect of facial pain on daily life:
☐ work activity.....# days per month missed.
☐ absence of school.....# days per month missed.
☐ Social, familial activities..... # days per month missed.

4. Current treatment

- For facial pain (including painkillers + number per day or per week):

.....
.....
.....
.....
.....
.....

- Other medication:

.....
.....
.....
.....
.....

- Current contraception:

.....

5. Previous treatments and tests.

a) Previous treatments by:

☐ General practitioner:.....
☐ Neurologist: *Medication or infiltration. If infiltration indicate where on page 3.*.....
☐ Specialist nose-throat-ear: *Sinus treated frontally, sphenoidally, ethmoidally, maxillary, left or right.* .....
☐ Ophtalmologist.....
☐ Dentist: *Indicate which tooth was treated on Figure 4 on page 7*. .....
☐ Chiropractor:.....
☐ Physiotherapy:.....
☐ Oral maxillofacial specialist: *Indicate which procedure, unilateral left or right or at the level of both jaw joints and indicate area of pain on Figure 3 on page 7*.....
☐ Pain specialist: *In case of infiltration indicate where on page 3.* .....

b) Previous tests:

☐ CT of the jaw joints.....
☐ CT sinus .....
☐ MRI head.....
☐ Orthopantogram .....
☐ MRI of the jaw joints .....
☐ Cervical MRI.....
☐ CT head.....

c) Medications already taken*:* (+ side effects)

- For facial pain (including **painkillers** + number per day or per week):

.....
.....
.....
.....
.....

- Other medication:

.....
.....
.....

- Previous contraception:

.....

6. Background

a) Personal history (except facial pain):

.....
.....
.....
.....
.....
.....
.....

b) Family history:

- Facial pain in family members:.....
  .....
  .....
  .....
  .....
- Significant medical history of family members: .....
  .....
  .....
  .....
  .....

7. Social life and lifestyle

I live in a household of ..... people and I have..... children.
Education:.....
Type of work: .....

I drink..... # cups of coffee a day.
I drink..... # alcoholic beverages
☐ per day ☐ per week ☐ per month

I smoke..... # cigarettes per day.
I practice a sport: ☐ No ☐ Yes, …… times per week
Weight:…….. kg, length:……..cm.
Blood pressure: ..... mmHg.

Fig. 3

RIGHT: LEFT:

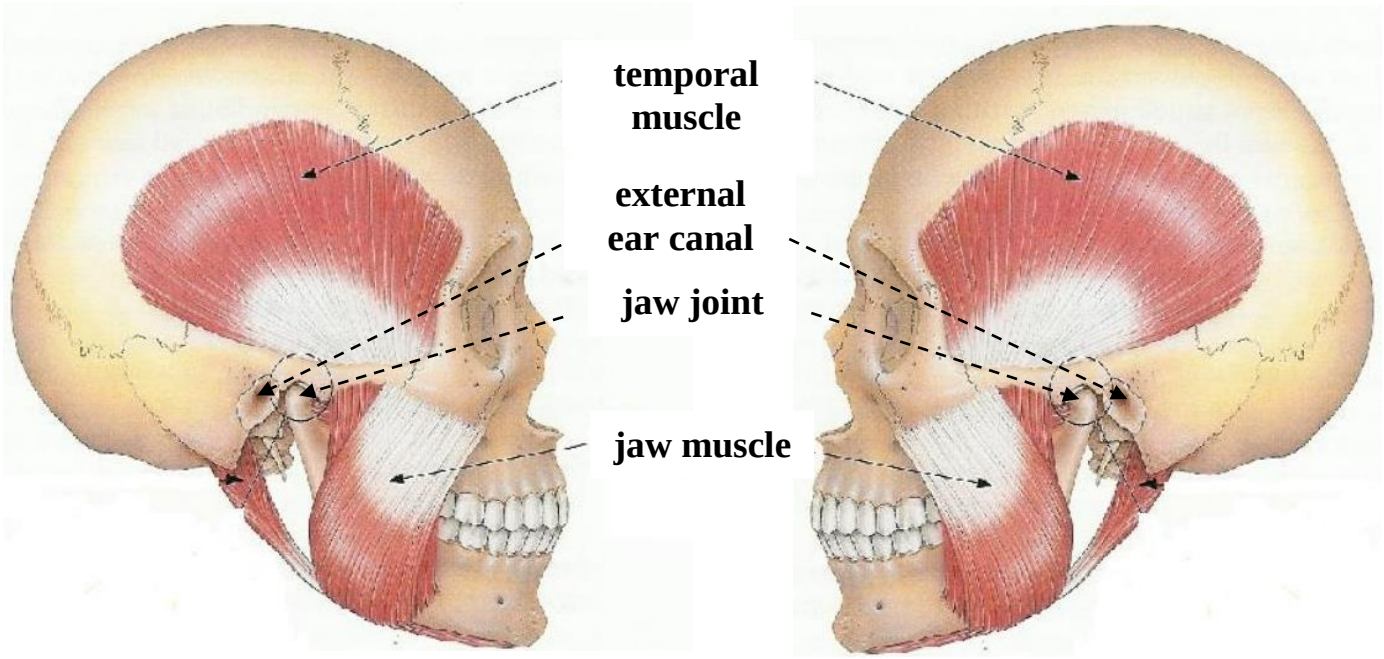


Fig. 4

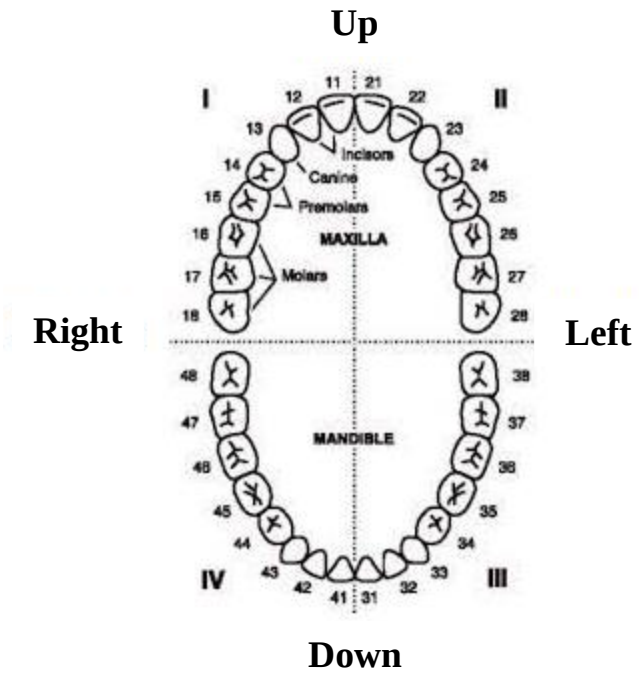
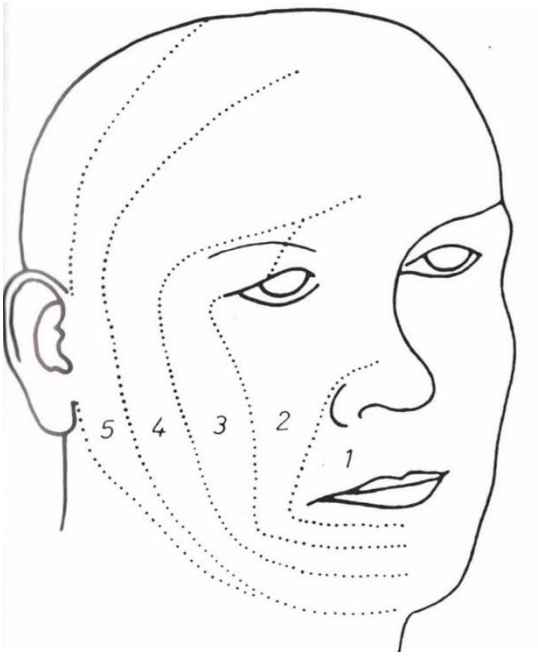


Fig. 5

Right Left



Indicate whether the pain predominates on the left or right.