010926
If QME: TIME STARTED: _____TIME ENDED:_____

Nurse:_____
INTP:_____
CERT #: _____

NAME:_____DATE:_____/_____/ 202___

Primary Treating Physician: Dr._____

Birth Date: ___ / ___ /_____ MALE FEMALE

Home Tel: ( ) _____Cell: ( )_____ Email: _____

Address:_____

Attorney's Name:_____ Attorney's Phone #:_____

1. YES NO Do you have any heart problems?
   Murmur Mitral Valve Problem Stent Pacemaker Defibrillator Rheumatic Heart Disease
2. YES NO Do you have any metal joint replacements? (NOT DENTAL FILLINGS)
3. **YES NO Do you have High Blood Pressure?**
4. **YES NO Do you have Diabetes?**
5. **YES NO Do you feel that stomach acids come up into your mouth or throat?**
6. **YES NO Do you have any Kidney problems?**
7. **YES NO Do you have a Thyroid problem?**
8. YES NO Do you have or have you had any of the following:
   HIV Hepatitis TB VD
9. YES NO Are you taking blood thinners? *Which one:*_____
10. YES NO Do you have any breathing problems?
    Asthma Shortness of Breath
11. YES NO Do you have any numbness or pins / needles feeling anywhere in your body?
    *Where:*_____
12. YES NO Do you have any Liver problems?
13. YES NO Do you have any Urinary problems?
14. YES NO Awakens at night to urinate: _____times per night
15. YES NO Have you ever had a Sleep Study Test?
    *When:*_____ *Apnea Results? YES NO*
16. YES NO Have you ever been given a CPAP mask to use at night to help you breathe?
17. YES NO Do you awaken in the morning with a headache in your temple/forehead areas?

History of Allergies: Penicillin Sulfa Erythromycin Seasonal Allergies

Please circle medications you are taking?

Pristiq Wellbutrin Effexor Celexa Cymbalta Prozac Lexapro Zoloft Paxil Omeprazole Prilosec Ibuprofen Motrin Advil Tylenol Aleve Naproxen Naprosyn Flexeril Tramadol Hydrocodone Vicodin Norco Oxycodone Ambien Zolpidem Alprazolam Ultram Gabapentin Neurontin Metformin Glipizide Cyclobenzaprine Hydrochlorothiazide Lisinopril Atenolol Thyroxine Atorvastatin
Medications For: Diabetes Sleep High Blood Pressure Pain Anti-Inflammatory Cholesterol (see attached sheet)

BELOW THE LINE TO BE COMPLETED BY THE DOCTOR:

	DX Pre-Injury	Increased After Injury	DX Post-Injury
Blood Pressure			
Diabetes			
Gastric Acid			
Kidney Problems			
Thyroid Problems Hypo Hyper			

History of Medication Usage

***How many times per Day?**
***For how long have they taken the Medication?**
***Dosage?**

What medications were you taking **before** the work injury?

The patient cannot remember at this time _____ None _____

Pain _____

Inflammation _____

Stress _____

Sleep _____

Gastric Reflux _____

Diabetes _____

High Blood Pressure _____

Thyroid Problem _____

Other_____

What medications are you **presently** taking?

The patient cannot remember at this time _____ None _____

Pain _____

Inflammation _____

Stress _____

Sleep _____

Gastric Reflux _____

Diabetes _____

High Blood Pressure _____

Thyroid Problem _____

Other_____

What medications were you taking **after** the work injury (But are no longer taking) How many times per Day? For how long have you taken the medication for?

The patient cannot remember at this time _____ None _____

Pain _____

Inflammation _____

Stress _____

Sleep _____

Gastric Reflux _____

Diabetes _____

High Blood Pressure _____

Thyroid Problem _____

Other_____

Patient to call the office with the names of the medications they take _____

YES	NO	Do you feel that you have dry mouth?	Sometimes
YES	NO	Do you have hoarseness?	Sometimes
YES	NO	Does the amount of saliva in your mouth seem to be too little?	Sometimes
YES	NO	Do you have any difficulties swallowing?	Sometimes
YES	NO	Does your mouth feel dry when eating a meal?	Sometimes
YES	NO	Do you sip liquids to aid in swallowing dry food?	Sometimes

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		Before the Injury	**After the Injury**
★	Do you have bad breath?	YES NO	YES NO
	What percentage of time do you have bad breath?	(0 to 100%)_____%	_____%
	How intense is your bad breath?	VAS _____	VAS _____
	How often do people tell you that you have bad breath?	VAS _____	VAS _____
	Does your bad breath interfere with your ability to interact with other people?	VAS _____	VAS _____
	Does your bad breath interfere with your ability to interact with your family?	VAS _____	VAS _____
	Does your bad breath interfere with your ability to have intimate Kissing with your significant other?	VAS _____	VAS _____
	Does your bad breath cause you embarrassment?	VAS _____	VAS _____
	Does your bad breath cause you stress?	VAS _____	VAS _____

Halitosis Meter Reading = _____

1 = No Odor 2 = Slight Odor 3 = Moderate Odor 4 =Strong Odor 5 = Intense Odor

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★ Since your work injury have you noticed that your taste feels bland? Yes No

Has there been a change in your perception of taste of **sweet, salty,** or **sour** foods? Yes No

If yes, From 0 to 10 how much do you feel your taste has changed? *VAS* _____

Was your change in taste caused by Covid-19 *Yes No*

If yes, has a doctor determined that you caught Covid at work? *Yes No*

Has a doctor determined that your GERD is work related? Yes No

I attest that all of the above is true.

Patient's Signature: X _____ **Date: _____/_____/202____**

Hand Dominance Right Left

In your work injury, did you injure your:

Right Shoulder Arm Elbow Wrist Hand Fingers

Left Shoulder Arm Elbow Wrist Hand Fingers

Do you have any difficulty using your hands to adequately grip a toothbrush and brush your teeth? Yes No

Do you have any difficulty using hands/fingers to adequately floss your teeth? Yes No

Does shoulder pain cause you any difficulty brushing and/or flossing your teeth? Yes No

Do you have any difficulty holding a toothpaste tube with one hand and using the other hand to open the toothpaste cap? Yes No

Do you have any difficulty squeezing toothpaste with one hand and holding the toothbrush with the other hand? Yes No

Do you have any difficulty using your hands to cut your food? Yes No

Do you have any difficulty using your hands to feed yourself? Yes No

Do you have any difficulty raising up your arm to comb or brush your hair? Yes No

Do you Smoke? Yes No

Have you ever smoked? Yes No

When did you stop smoking? _____ months ago _____ years ago

How much do you smoke? _____ cigarettes/day

How many years were you a smoker? _____

Did your smoking usage increase after the industrial injury? Yes No *If yes,* ____cigarettes per day

Do You Drink Alcohol? Yes No *If yes, How much?* _____

Do you use recreational drugs? Yes No *if yes, describe:*_____

Have you used amphetamines? Yes No *if yes, When?*_____

I attest that all of the above is true.

Patient's Signature: X _____ **Date: _____/_____/202____**

HAWTHORNE RESEDA ANAHEIM REDLANDS SACRAMENTO

PRIVATE WCAB QME PQME APQME AME UNREPRESENTED PERSONAL INJURY

Name: _____ **M___ F___ Date:** _____/_____/202___ **Interpreter:** _____

Date of Injury:_____ **PTP: DR**._____

Employment History

Employed at: _____for _____ years months

Job Title: _____

Worked _____Days per week; Worked _____Hours per day

Right Left Hand Dominant

What did patient do at the job?

Job Requirements: driving walking standing sitting squatting twisting

bending forward side bending reaching below shoulder level reaching above shoulder level

pushing pulling grasping gripping

lifting up to maximum of ____lbs. carrying up to maximum _____lbs.

typing using a computer mouse: R L non-ergonomic: desk chair work station

non-fully adjustable chair with non-adjustable arm rest computer monitor located in: F R L

cradling the phone on: R L writing

Current Work Status: Disabled Still working at the same company Not Working/Retired

Date Stopped working _____

Presently working at different company_____ as _____

Job duties:

Job Requirements: driving walking standing sitting squatting twisting

bending forward side bending reaching below shoulder level reaching above shoulder level

pushing pulling grasping gripping

lifting up to maximum of ____lbs. carrying up to maximum _____lbs.

typing using a computer mouse: R L non-ergonomic: desk chair work station

non-fully adjustable chair with non-adjustable arm rest computer monitor located in: F R L

cradling the phone on: R L writing

(If Applicable) Reviewed History of Trauma with patient as per the report of Dr. _____ Date: ____ /____/202___

Patient's Signature: X _____ **Date: _____/_____/202____**

History of Industrial Injury

(Patient is a Poor Historian: Yes No)

Orthopedic injuries to:	Freq-%	VAS
Neck		
R Shoulder		
L Shoulder		
R Arm		
L Arm		
R Elbow		
L Elbow		
R Wrist		
L Wrist		
R Hand		
L Hand		
R Fingers		
L Fingers		
Upper Back		
Mid Back		
Low Back		
R Hip		
L Hip		
R Leg		
L Leg		
R Knee		
L Knee		
R ankle		
L ankle		
R foot		
L Foot		

1)

2)

3)

CT: repetitive trauma resulting in orthopedic injuries

If MVA Driver Passenger Right Rear Seat Left Rear Seat Vehicle Hit On: R L Front Rear

Wearing a seatbelt? Yes No Airbag Deployed? Yes No Thrown About? Yes No

Struck Mouth Face? Steering Wheel Door Window Struck back of head on headrest? Yes No

Direct Trauma to the Face/Jaw? R L Scars? _____ Fractured Jaw? Yes No

Fractured Teeth? # _____Lost Teeth? #_____

Orthopedic pain causing clenching/bracing of facial muscles Yes No

Developed stressors in response to industrial orthopedic injuries Yes No

Stressors at Work Heavy workload Long or inflexible hours Tight deadlines Lack of control

Conflicting or uncertain job expectations Night shifts Lack of support Bullying Poor relationships

Clenching/Bracing of facial muscles in response to stress Yes No

Did the bruxism begin after the you started having work related pain/stress? Yes No ____ Days after ____Weeks after

Bruxism Clenching Day Night

Grinding Day Night

Bracing Facial Musculature Day Night

Bruxism: _____% of Time _____ VAS Intensity

Pre-Existing Conditions

Headaches _____% of time _____intensity of Headache on VAS _____

Vertex R L Forehead R L Temple R L Occiput R L Behind Eyes

Have you ever been diagnosed with migraines? Yes No *if yes,* _____

R L B Facial Pain _____% of time _____intensity of Facial Pain on VAS _____

R L B TMJ Pain _____% of time _____intensity of TMJ Pain on VAS _____

Bruxism: _____% of time _____intensity of Bruxism on VAS _____

If a nightguard was made (year made) _____ *Still uses a nightguard? Y N*

Reason stopped using nightguard? Does not fit Lost Wore Out Broken

Did you have any prior problems eating hard or chewy food? Yes No

Did you have any prior problems speaking for prolonged periods of time? Yes No

I attest that all of the above is true.

Patient's Signature: X _____ **Date: _____/_____/202____**

Treatments Received Due to the Industrial Injury

Surgery to:

Neck R L Shoulder R L Arm R L Elbow R L Wrist R L Hand R L Fingers

R L Thumb Back R L Hip R L Knee R L Leg R L Feet R L Ankles

How many times? _____

Tx Received:

Physical Therapy Chiropractic Manipulations Acupuncture Injections: Steroid Spinal Trigger Point

Psychological Therapy: Evaluated by _____

Neurologist: Evaluated by _____

Prior History

Past Medical History: None

Past Surgeries: None

History of Prior Industrial Injuries: None

History of Non-Industrial Injuries: None

MVA_____ Injured_____ No facial/Jaw problems or pain Residual Problems: None_____

MVA_____ Injured_____ No facial/Jaw problems or pain Residual Problems: None_____

MVA_____ Injured_____ No facial/Jaw problems or pain Residual Problems: None_____

MVA_____ Injured_____ No facial/Jaw problems or pain Residual Problems: None_____

Any Injuries <u>After</u> the Date of Industrial Injury (Industrial or Non-Industrial):

None

Dental History

When was the last time you were seen by a dentist, besides in our office?

_____ Years ago _____ Months ago _____ Weeks ago

_____Other _____Never

When was the last time you had Full Mouth X-Ray taken? _____

To the best of your ability, please list the name(s), addresses and phone numbers of your prior dentist(s):

_____

_____

Dental Treatments: Regular dental checkups/polishing of teeth

Every: 6 months _____ year Last time patient had teeth cleaned _____

Name of Dentist: _____**Phone #:** _____

Dentist's Address: _____

Name of Dentist: _____**Phone #:** _____

Dentist's Address: _____

Dental Treatments Received Since Industrial Injuries:

***If yes,* Name of Dentist:** _____Phone #: _____

Gum Treatments

Restorations on teeth in UR UL LR LL

Root Canals in UR UL LR LL

Crowns in UR UL LR LL

Implants in UR UL LR LL

Upper Lower Partial Denture

Upper Lower Complete Denture

Upper Lower Bruxism Oral Appliance Oral Sleep Appliance

Extractions: Wisdom teeth Teeth #_____

Missing Teeth?_____ Prior to the industrial injury?# _____ After the Injury?#_____

Present Symptoms

Weight Gain Loss _____ lbs **Loss due to** Facial Pain Diet
Present Weight _____Kg **Height** _____ cm **Frame** Small Medium Large

Snores	Yes	No	**Pre-existing**	**Aggravated**	**After Work Injury**
Gasps for Air at Night	Yes	No	**Pre-existing**	**Aggravated**	**After Work Injury**
Palpitations on Awakening	Yes	No	**Pre-existing**	**Aggravated**	**After Work Injury**
Breathing Cessation at Night	Yes	No	**Pre-existing**	**Aggravated**	**After Work Injury**
Patient had Sleep Study	Yes	No			

If yes for sleep study: Date of study _____ , ___Patient diagnosed with a Sleep Disorder___Patient does not know results, Given mask during Sleep Study Used CPAP during Sleep Study Patient given CPAP

Patient uses CPAP ___ times per week at night for ___ hours , Patient cannot tolerate CPAP. ***X*** _____

Headaches On Top of Head Temple Forehead Occipital Behind the Eyes
R L R L R L
Occasional, Intermittent, Frequent, Constant, Dull, Aching, Burning, Stabbing, Electrical,
Minimal, Slight, Moderate, Severe Sharp, Shooting, Numbness, Pins, Needles, Pulsing
_____ % of Time _____ VAS Started Approx.: _____

Do you think your bruxism may have caused you to have headaches? Yes No

Right Face Pain Occasional, Intermittent, Frequent, Constant, Dull, Aching, Burning, Stabbing, Electrical,
Minimal, Slight, Moderate, Severe Sharp, Shooting, Numbness, Pins, Needles, Pulsing
_____ % of Time _____ VAS

Left Face Pain Occasional, Intermittent, Frequent, Constant, Dull, Aching, Burning, Stabbing, Electrical,
Minimal, Slight, Moderate, Severe Sharp, Shooting, Numbness, Pins, Needles, Pulsing
_____ % of Time _____ VAS Started Approx.: _____

Do you think your bruxism may have caused you to have face pain? Yes No

Noises in TMJ R L Grinding, Clicking Started Approx.: _____
If applicable, Pre-Injury / TMJ Noise VAS_____ Post Injury / TMJ Noise VAS_____

Right TMJ Pain Occasional, Intermittent, Frequent, Constant, Dull, Aching, Burning, Stabbing, Electrical,
Minimal, Slight, Moderate, Severe Sharp, Shooting, Numbness, Pins, Needles, Pulsing
_____ % of Time _____ VAS

Left TMJ Pain Occasional, Intermittent, Frequent, Constant, Dull, Aching, Burning, Stabbing, Electrical,
Minimal, Slight, Moderate, Severe Sharp, Shooting, Numbness, Pins, Needles, Pulsing
_____ % of Time _____ VAS Started Approx.: _____

Limited Opening of the Mouth Yes No

Locking Yes No Closed _____ X per day wk month Open _____ X per day wk month

*First locked*_____

Can self-manipulate Jaw to unlock? Yes No

★ **Difficult and painful to chew hard food:** Face TMJ Teeth
R L R L

Bite feels off Yes No

Facial Pain Smiling Yawning

Soreness of teeth upon waking up in the morning? Yes No

Soreness in Face/Jaw Upon Awakening? Yes No R L

Teeth are sensitive to hot and cold? Yes No

Bleeding Gums? Yes No

★ **Speech Dysfunction** Indistinct Articulation, Hoarseness, "Cotton Mouth", Missing Upper Anterior Teeth,

Cannot Talk for Long Periods of Time Due to Pain Jaw Tiredness Can Speak Max. Time ____Minutes,

Voice Changes In: Tone Pitch Slurring Drooling People Asking Patient To Repeat Themselves

Ear Problems R L Both Ringing Pain Pressure Loss of Hearing Itching Buzzing Static

Sleep Disturbances Yes No

Fatigue Yes No

Generalized tenderness all over the body? Yes No

Stress Increases Pain? Yes No

Prior Injuries to Face / Jaw Yes No

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze **1** = slight chance of dozing **2** = moderate chance of dozing **3** = high chance of dozing
It is important that you circle a number (0 to 3) on each of the questions.

Siting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place – for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total Score:

Activities of Daily Living VAS

If your facial pain is aggravated by eating **hard or chewy food**, what is your pain level? YES NO VAS _____

If your face pain is aggravated by prolonged **speaking,** what is your pain level? VAS _____

Maximum time able to speak continuously _____Min

People ask you to repeat yourself because they do not **understand** you? YES NO VAS _____

Is your facial pain aggravated by intense **kissing**? YES NO VAS _____

Does your facial pain interfere with your ability to get enough **sleep**? YES NO VAS _____

Does the **pressure** on your face while you are **sleeping** result in face or jaw pain? YES NO

Does your facial pain interfere with your ability to participate in **social activities**? YES NO VAS _____

Does your facial pain interfere in your **relationship** with your family members or significant other? YES NO VAS _____

Does your facial pain interfere with your ability to **concentrate**? YES NO VAS _____

Does your facial pain cause you to be **irritable/angry**? YES NO VAS _____

Does your facial pain cause you to **experience stress**? YES NO VAS _____

Communication / Talking

- You **can** talk as much as you want **without** facial pain, jaw tiredness or discomfort.
- You **can** talk as much as you want, but talking causes **some** facial pain, jaw tiredness or discomfort.
- You **can not talk as much** as you want because of facial pain, jaw tiredness or discomfort.
- You **can not talk much at all** because of your facial pain, jaw tiredness or discomfort.
- Your facial pain **prevents you from talking at all** except for answering yes or no or only some words at a time.

Eating / Chewing

- You can eat and chew anything you want **without facial pain**, discomfort or jaw tiredness.
- You can eat and chew most anything you want, but it **sometimes causes facial pain**, discomfort or jaw tiredness.
- You **cannot eat hard or chewy foods,** because it **often causes facial pain**, discomfort or jaw tiredness.
- You **must eat only soft foods** (consistency of scrambled eggs or less) because of your facial pain, discomfort or jaw tiredness.
- You must **stay on a liquid diet** because of your facial pain.

Hard Foods: You must stay away from eating hard foods which includes: YES NO

Tough meats, hard bread, nuts, apples, carrots, crunchy vegetables, hard candy

Chewy Foods: You must stay away eating chewy foods which includes: YES NO

Chewing gum, steak, pizza crusts, and bagels; candies like: taffy, caramel, licorice, gummy bears

Soft Foods: You can only eat soft or liquid type foods with the consistency of scrambled eggs or less. YES NO

I attest that all of the above is true.

Patient's Signature: X _____ **Date: _____/_____/202___**

Activities of Daily Living

Self-Care Hygiene

Brushing Teeth
- None Mild Moderate Severe
- Due to pain in facial musculature

Compromised
- Due to limited opening of the mouth
- Due to shoulder, arm, elbow, wrist, hand, fingers injury
- Due to lack of motivation, lack of concentration, and/or forgetfulness caused by stressors

Flossing Teeth
- None Mild Moderate Severe
- Due to pain in facial musculature

Compromised
- Due to limited opening of the mouth
- Due to shoulder, arm, elbow, wrist, hand, fingers injury
- Due to lack of motivation, lack of concentration, and/or forgetfulness caused by stressors

Communication

Speak for Extended Period of Time
Max Time Speak _____Min
- None Mild Moderate Severe
- Due to pain in facial musculature

Speaking Difficulty
- None Mild Moderate Severe
- Due to dryness of the mouth causing hoarseness and or wakes up with hoarseness

Asked to Repeat Themselves
- None Mild Moderate Severe
- Due to facial pain • Due to dryness of mouth • Due to missing anterior teeth

Motor Function

Mastication
- None Mild Moderate Severe
- Due to pain in facial musculature • Due to pain in teeth
- Due to dryness of the mouth

Tasting
- None Mild Moderate Severe VAS _____
- Due to dryness of the mouth causing a change in taste: Bitter Metallic Bland

Swallowing
- None Mild Moderate Severe
- Due to dryness of the mouth

Bruxism
- None Mild Moderate Severe
- In response to pain • In response to resultant stress
- May be due to side effect of anti-depressant medications taken on an industrial basis
- Had Sleep Study, and may be contributed to by nocturnal obstructions of the airway

Sexual Function

Kissing, Oral Activities
- None Mild Moderate Severe
- Due to pain in facial musculature
- Due to Halitosis

Clinical Examination

Unspecified Rheumat. Yes No Tender Phalanges R L Multiple Tender Points Sleep Disturbances Fatigue

Facial Palsy Right Left

Facial Atrophy Right Left

Facial Hypertrophy Right Left

Dyskinesia Yes No

Tongue Protrusion Right Left Straight

Range of Motion:

Maximum Interincisal Opening _____mm *Pain:* R L Face TMJ _____VAS
Right Lateral _____mm *Pain:* R L Face TMJ _____VAS
Left Lateral _____mm *Pain:* R L Face TMJ _____VAS
Protrusion _____mm *Pain:* R L Face TMJ _____VAS

Jaw Deviation **Deflection** Opening Closing R L _____mm *S-Form Deviation* R L

Capsulitis Yes No **Right** Lateral Pole *Pain:* _____VAS **Left** Lateral Pole *Pain:* _____VAS
Right VIA EAM *Pain:* _____VAS **Left** VIA EAM *Pain:* _____VAS

Joint Noises (Manual) Right Left Crepitus Clicking Translational Lateral

		Tenderness:	***Palpable Taut Bands / Trigger Points:***		***WRP To:***
Temporalis	R	_____VAS	Y N	RPTHA	Face Temple Forehead Eye Teeth
	L	_____VAS	Y N	RPTHA	Face Temple Forehead Eye Teeth
Masseter	R	_____VAS	Y N	RPFP	Face Temple Forehead Eye Teeth
	L	_____VAS	Y N	RPFP	Face Temple Forehead Eye Teeth
Occipitals	R	_____VAS		RPOHA	Face Temple Forehead Eye Top
	L	_____VAS		RPOHA	Face Temple Forehead Eye Top
Trapezius	R	_____VAS	Y N		Face Temple Forehead Eye Neck Occiput
	L	_____VAS	Y N		Face Temple Forehead Eye Neck Occiput
SCM	R	_____VAS	Y N		Face Temple Forehead Eye Occiput
	L	_____VAS	Y N		Face Temple Forehead Eye Occiput
Lat. Pterygoid	R	_____VAS	Y N		Face Temple Forehead Eye Neck
	L	_____VAS	Y N		Face Temple Forehead Eye Neck

Class I II III **Overbite** _____mm **Overjet**_____ mm **Midline Deviation** _____mm R L

Crossbite Ant. R L **Closed Bite** **Collapsed Bite** **Unstable Bite**

Open Bite Ant. R L

Tongue Thrust Ant. R L Both Sides **Tori** Max Man

Scalloping Right Left Minimal Slight Moderate Significant

Buccal Mucosal Ridging Right Left Minimal Slight Moderate Significant

Occlusal Wear None Apparent Right Left Ant. . Minimal Slight Moderate Significant

Patient Has: FUD FLD UPD LPD

Fractured Dentures Upper Lower Full Partial

Abfractions on Teeth # 2 3 4 5 6 7 8 9 10 11 12 13 14 15 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Missing Teeth # 2 3 4 5 6 7 8 9 10 11 12 13 14 15 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Missing Third Molars # 1 16 17 32

Gum Recession Teeth # 2 3 4 5 6 7 8 9 10 11 12 13 14 15 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Fractured Teeth # _____

Fractured Bridge or Crowns #_____

Visually Apparent Decayed Teeth #_____

Broken Dental Filling #_____

Teeth Sensitive to Percussion #_____

Teeth sensitive to Periapical Palpation #_____

Teeth with Mobility #_____

Bleeding Gums Yes No

Inflamed Gingiva Yes No

Scars? *Detail:* _____

Malampati:_____ **Friedman:**_____

Diagnostic Tests

Blood Pressure _____ / _____

Ultrasound Doppler Analysis

Click

Opening R ____ L ___ RRL ____ RLL ___

Closing R ____ L ___ LRL ____ LLL ___

No Clicking was Auscultated _____

Damage

Translation R ____ L ___ Lateral R ____ L ___

Muscle Temperature in C°

R Temporalis ____ L Temporalis ____

R Masseter ____ L Masseter ____

R SCM ____ L SCM ____

R Trapezius ____ L Trapezius ____

Diagnostic Bite Force Analysis /

Musculoskeletal Functional Capacity

Right _____ Newtons Left _____ Newtons

EMG Results

Right Masseter	**Left Masseter**
_____µV Rest	_____µV Rest
_____ µV Contraction	_____ µV Contraction
_____ µV Peak	_____ µV Peak
Right Temporalis	**Left Temporalis**
_____µV Rest	_____µV Rest
_____ µV Contraction	_____ µV Contraction
_____ µV Peak	_____ µV Peak

Elevated Muscular Activity Yes No

Incoordination/Aberrant Function Yes No

Diagnostic Autonomic Nervous System

Before: O2 ____ Pulse ____

After: O2 ____ Pulse ____

Amylase Test _____

Salivary Diagnostic Testing

Visual Evaluation

Tissue Analysis of Lips Dry Cracked Wet

Tissue Analysis of Tongue Fissuring Dry White Patches

Quality of Saliva Cloudy Ropey Viscous Bloody

Saliva Pooling at Floor of Mouth Yes No

Adherence of Tongue Depressor on inside of cheek Yes No

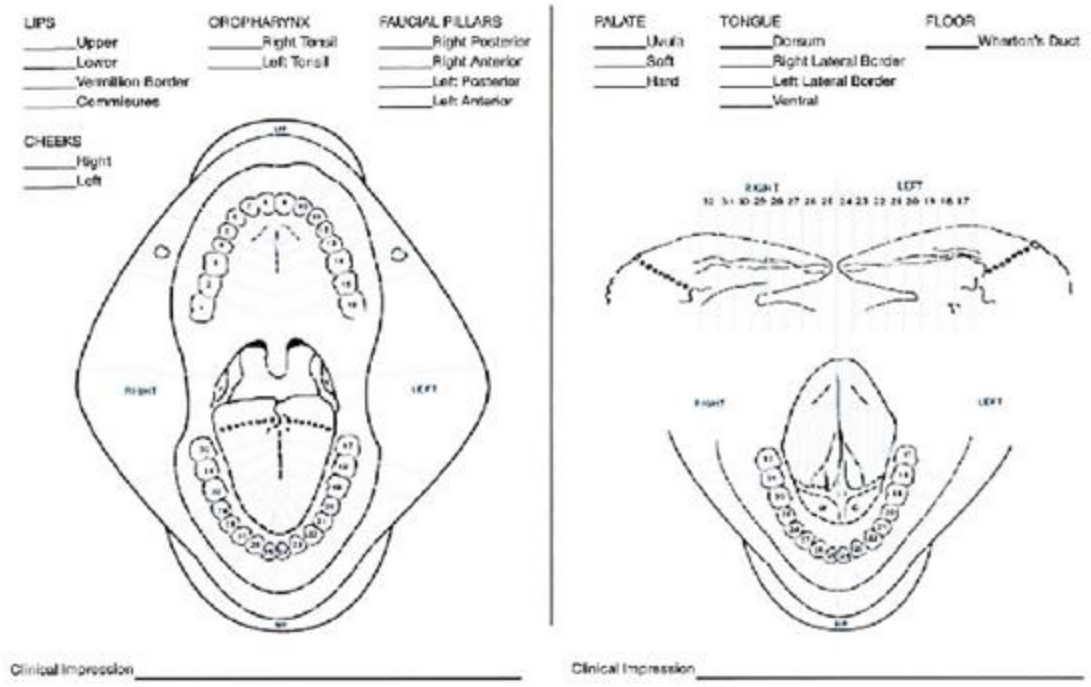
Salivary Flow Unstimulated Less than 0.1mL Greater than 0.1mL

Stimulated Less than 0.5mL Greater than 0.5mL

Salivary pH Analysis _____

Gingival Bleeding Yes No

Oral Cancer Screening Form



_____DFV

Diagnosis

____S09.93XA Traumatic Injury to Face Mandible Teeth # _____

____G51.0 Facial Palsy Right Left

____G50.0 Trigeminal Nerve Neuropathic Pain / Central Sensitization

____F45.8 Bruxism

____M79.1 Myalgia of Facial Muscles

____M65.80 Capsulitis / Inflammation Right Left

____M26.69 Internal Derangement Right Left

____M26.69 Osteoarthrosis Right Left

____M26.69 Osteoarthritis Right Left

____ K11.7 Xerostomia

____K05.6 Inflammation of the Gums

____G51.0 Halitosis / Oral Malodor

____R19.6 Suggestions of an Unspecified Rheumatological / Systemic Condition

Other: _____

_____

Trigeminal Nerve Neuropathic QST Testing

QST

Right Forearm	_____VAS	_____Seconds	Sharp	Electrical	Burning
Right Temporalis	_____VAS	_____Seconds	Sharp	Electrical	Burning
Right TMJ	_____VAS	_____Seconds	Sharp	Electrical	Burning
Right Masseter	_____VAS	_____Seconds	Sharp	Electrical	Burning
Left Temporalis	_____VAS	_____Seconds	Sharp	Electrical	Burning
Left TMJ	_____VAS	_____Seconds	Sharp	Electrical	Burning
Left Masseter	_____VAS	_____Seconds	Sharp	Electrical	Burning
_____	_____VAS	_____Seconds	Sharp	Electrical	Burning

QST Cold

Right Temporalis	_____VAS	Sharp	Electrical	Burning
Right TMJ	_____VAS	Sharp	Electrical	Burning
Right Masseter	_____VAS	Sharp	Electrical	Burning
Left Temporalis	_____VAS	Sharp	Electrical	Burning
Left TMJ	_____VAS	Sharp	Electrical	Burning
Left Masseter	_____VAS	Sharp	Electrical	Burning
_____	_____VAS	Sharp	Electrical	Burning

QST After Bilateral SPGB, if necessary

Right Temporalis	_____VAS	_____Seconds	Sharp	Electrical	Burning
Right TMJ	_____VAS	_____Seconds	Sharp	Electrical	Burning
Right Masseter	_____VAS	_____Seconds	Sharp	Electrical	Burning
Left Temporalis	_____VAS	_____Seconds	Sharp	Electrical	Burning
Left TMJ	_____VAS	_____Seconds	Sharp	Electrical	Burning
Left Masseter	_____VAS	_____Seconds	Sharp	Electrical	Burning
_____	_____VAS	_____Seconds	Sharp	Electrical	Burning

Diagnostic Photographs

Lateral Border of the Tongue Scalloping

Buccal Muccosal Ridging Right Left

Occlusal Wear Anterior Generalized

Bleeding on Flossing

Tongue Blades adhering to inside of cheeks

Erosion Class I II III Occlusion

Abfractions

Cervical Decay

Generalized Decay

Biofilm on Teeth

Biofilm on Gums

Swollen Gums

Gum Recession

Maxillary Torus

Mandibular Tori

Deviation of Tongue on Protrusion Right Left

Deviation of Mandible Upon Opening Right Left

Facial Palsy Right Left

Broken Porcelain on Bridge

Broken Denture

Missing Broken Teeth #:_____

Open Bite Anterior Right Left

Cross Bite Anterior Right Left

Collapsed Bite Unstable Bite Off Bite

Facial Scarring

Hypertrophy of Masseter Muscle Right Left Bilateral

Tongue Trust Anterior Lateral Right Left

Orthodontic Brackets

Fibroma

Leukoplakia

Treatment Plan

_____ Orthotic Appliance / Resilient Orthotic OAOA OSA TRD Diagnostic Splint
_____ Craniofacial Exercises
_____ Trigger Point Injections
_____ Sphenopalatine Ganglion Blocks
_____ Trigeminal Pharyngoplasty
_____ FMX
_____ Panorex
_____ MRI if locking Persists
_____ Surgical Consultation if Locking Persists

_____ Sleep Study Report Needed
_____ Polysomnogram Needed
_____ Physical Therapy Treatment Needed
_____ Psychological Consultation Needed
_____ Neurological Care Needed
_____ Orthopedic Consultation Needed
_____ Rheumatological Consultation to rule out Fibromyalgia Needed
_____ Plastic Surgery Consultation Needed for _____
_____ ENT Consultation Needed for: Ringing in ears Hearing Loss _____
_____ Internal Medicine Consult Needed for: HBP Diabetes GERD Kidney Thyroid_____

_____ Referral for Evaluation And Treatment with Prosthodontic/Periodontist Specialist
_____ Oral Surgery Consultation
_____ Orthodontic Consultation
_____ Dental Consultation for: Treatment for Decay Fractured Teeth Xerostomia / Periodontal Disease

_____ Patient to get Dental Records / FMX
_____ Patient to get Prescriptions from Pharmacy
_____ I NEED ALL MEDICAL AND DENTAL RECORDS

_____ Patient informed they must see any dentist for X-rays to determine if any fracture, decay, and / or periodontal disease is present that can be caused or aggravated by their industrially related xerostomia or bruxism conditions.

_____ Patient informed they must see any dentist for the decay and / or periodontal disease that can be caused or aggravated by their industrially related xerostomia.

_____ Patient informed that if they require dental treatment for decay or fractured of teeth that was caused or aggravated by their industrially related xerostomia, or trauma, or bruxism, that no treatment will be performed by our office for the decay or fractured teeth until authorization and payment is made to our office by the workers compensation insurance company; and therefore they must seek the required treatment at any dental office to be paid for by the patient them self.

Dr. Signature: X _____ **Date: _____/_____/202____**