AAGO SOAP Form – *SUBJECTIVE*

PATIENT_____ **DATE**_____

010 WHAT ARE THE CHIEF CONCERNS FOR WHICH YOU ARE SEEKING TREATMENT?

❑ Orthodontic (*Please explain)*_____

❑ Pain, Sleep or Airway (*Please explain)*_____

❑ Cosmetic, Restorative or other (*Please explain)*_____

Please number the complaints with #1 being the most severe, #2 the next most severe, etc.

Symptoms from which you most desire relief:

TMD / PAIN COMPLAINTS:

#1 = the most severe symptom

___Jaw clicking / grating
___Jaw locking / stiffness
___Limited mouth opening
___Mouth doesn't open straight
___Pain when chewing
___Jaw pain
___Unstable bite
___Headaches
___Facial pain
___Neck pain
___Ear pain or stuffiness
___Ringing in the ears
___Difficulty swallowing
___Facial muscle fatigue
___Migraines
___Other_____

___Dizziness
___Morning head pain
___Morning hoarseness
___Teeth grinding at night

SLEEP / BREATHING COMPLAINTS

___CPAP intolerance
___Difficulty falling asleep
___Fatigue
___Frequent heavy snoring
___Frequent heavy snoring which affects the sleep of others
___Gasping when waking up
___Nighttime choking spells
___Significant daytime drowsiness
___Sleepy when driving
___Witnessed apneic events (stopping breathing)

011 SLEEP HISTORY

Have you been previously diagnosed with Obstructive Sleep Apnea? ❑ Yes ❑ No If yes, when? _____

Sleep: ❑ Yes ❑ No Do you get to sleep well, stay asleep well, and wake up feeling rested?

❑ Yes ❑ No Bruxism ❑ Yes ❑ No Witnessed apneas
❑ Yes ❑ No Clenching ❑ Yes ❑ No Dry mouth
❑ Yes ❑ No Waking up & having difficulty sleeping ❑ Yes ❑ No Gasping
❑ Yes ❑ No Excessive movements ❑ Yes ❑ No Restless legs

Frequency of nocturnal urination _____ (# of times) per nt. Getting up _____ (# of times) per night.

Awake: ❑ Yes ❑ No Awakens un-refreshed
❑ Yes ❑ No Has morning headaches
❑ Yes ❑ No Problematic Daytime Sleepiness

Naps: ❑ Never ❑ Occasionally

Snoring: ❑ Never ❑ Seldom ❑ Often ❑ Daily (Severity) ❑ Light ❑ Mod ❑ Loud Worse: ❑ on back ❑ after alcohol

CPAP: ❑ Never tried ❑ Tolerated ❑ NOT tolerated (Ck reason):

❑ Mask leaks ❑ Claustrophobic ❑ Inability to fit mask ❑ Discomfort from headgear ❑ Restricts movements ❑ Noisy
❑ Cumbersome ❑ Doesn't resolve symptoms ❑ Other: _____

012 SPECIFIC SYMPTOMS

❑ Check if head, neck, back and jaw joints are currently without pain or discomfort

HEAD PAIN

❑ Yes ❑ No Entire head (generalized)
❑ Yes ❑ No Top of the head
❑ Yes ❑ No Pain or discomfort on turning the head
❑L ❑R ❑B Front of your head (frontal)
❑L ❑R ❑B Back of your head
❑L ❑R ❑B Temples

JAW PAIN

❑L ❑R ❑B Jaw pain - on opening
❑L ❑R ❑B Jaw pain - while chewing
❑L ❑R ❑B Jaw pain - at rest

JAW SYMPTOMS

❑L ❑R ❑B Jaw clicking
❑L ❑R ❑B Jaw popping
❑ Yes ❑ No Jaw locks closed
❑ Yes ❑ No Jaw locks open
❑ Yes ❑ No Do you ever hear grating sounds from your jaw joints?
❑ Yes ❑ No Do your jaw joints become tired frequently?

MOUTH & NOSE RELATED CONDITIONS

❑ Yes ❑ No Stuffiness at night
❑ Yes ❑ No Pain or discomfort on yawning
❑ Yes ❑ No Burning tongue
❑ Yes ❑ No Frequent biting of cheek
❑ Yes ❑ No Teeth clenching
❑ Yes ❑ No Dry mouth
❑ Yes ❑ No Broken teeth
❑ Yes ❑ No Pain or discomfort on sneezing
❑ Yes ❑ No Pain or discomfort on shouting
❑ Yes ❑ No Pain or discomfort while speaking

EYE-RELATED CONDITIONS

❑ Yes ❑ No Blurred vision
❑ Yes ❑ No Eye pain
❑ Yes ❑ No Pain or pressure behind eyes

THROAT, NECK & BACK CONDITIONS

❑ Yes ❑ No Back pain - lower
❑ Yes ❑ No Back pain - middle
❑ Yes ❑ No Back pain - upper
❑ Yes ❑ No Constant feeling of a foreign object in throat
❑ Yes ❑ No Difficulty in swallowing
❑ Yes ❑ No Chronic sore throat
❑ Yes ❑ No Limited movement of neck
❑ Yes ❑ No Neck pain
❑ Yes ❑ No Neck clicking, popping, or grating noises on movement
❑ Yes ❑ No Numbness of hands or fingers
❑ Yes ❑ No Chronic sinusitis
❑ Yes ❑ No Tightness in throat
❑ Yes ❑ No Thyroid enlargement
❑ Yes ❑ No Sciatica
❑ Yes ❑ No Scoliosis
❑ Yes ❑ No Pain or discomfort moving arms or shoulders
❑ Yes ❑ No Shoulder stiffness
❑ Yes ❑ No Swelling in the neck
❑ Yes ❑ No Swollen glands

EAR-RELATED CONDITIONS

❑L ❑R ❑B Ear pain
❑ Yes ❑ No Tingling in the hands or fingers
❑L ❑R ❑B Ear stuffiness
❑L ❑R ❑B Pain in front of the ear
❑L ❑R ❑B Buzzing in the ears
❑L ❑R ❑B Tinnitus (ringing in the ears)
❑L ❑R ❑B Pain behind the ear
❑L ❑R ❑B Hearing loss

Other:

_____

_____

013 LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

Practitioner Specialty Treatment & Approximate Date

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

014 HEAD PAIN NATURE

LOCATION

Which side are the headaches worse? (choose ONE)

❑L ❑R ❑B

Headache spreads to (choose ONE):

- ❑ the temple
- ❑ the back of the head
- ❑ the forehead

DURATION

How long does your pain last? (choose ONE from below):

- ❑ hours / weeks
- ❑ seconds
- ❑ minutes
- ❑ hours
- ❑ days
- ❑ weeks
- ❑ months

SEVERITY ON A SCALE OF 0-10

0 = no pain, 10 = worst pain imaginable

_____ Jaw Pain on a numeric pain scale
_____ Headaches on a 0-10 pain scale
_____ Neck Pain on a numeric pain scale
_____ Facial Pain on a 0-10 pain scale

FREQUENCY

How frequent is your pain? (choose ONE):

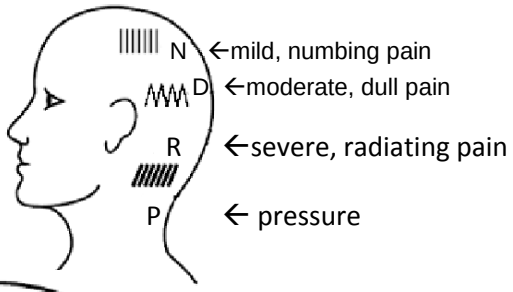
❑ seldom ❑ frequent
❑ occasional ❑ every day

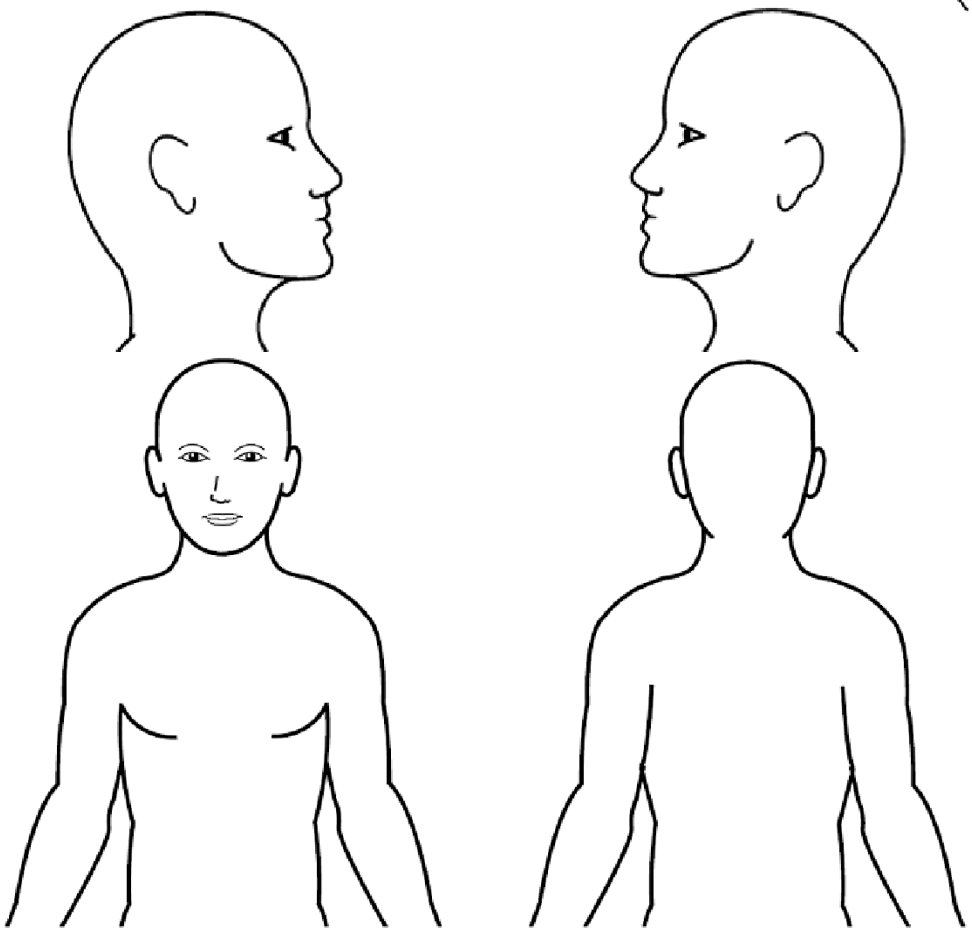
When are your symptoms worse? (Choose ONE from below):

- ❑ in the morning
- ❑ at work
- ❑ at school / home
- ❑ hay-fever season
- ❑ at the end of the work day
- ❑ rainy weather

015 DRAW YOUR PAIN PATTERN FOLLOWING THIS KEY:

MILD PAIN	|||||	B = burning
MODERATE PAIN	\/\/\/\/\	D= dull
SEVERE PAIN	///////	N = numbing
		P = pressure
		S = sharp
		T = tingling
		R = radiating





016 PAIN NATURE (Continued)

NATURE OF PAIN

How would you describe the type of pain you experience?
- ❑ sharp
- ❑ dull
- ❑ aching
- ❑ deep
- ❑ superficial
- ❑ throbbing
- ❑ diffused
- ❑ constant
- ❑ intermittent
- ❑ cyclic

When having pain, do you experience:
- ❑ dizziness
- ❑ lightheadedness
- ❑ double-vision
- ❑ fatigue
- ❑ nausea
- ❑ forgetfulness
- ❑ sensitivity to light (photophobia)
- ❑ sensitivity to noise
- ❑ throbbing
- ❑ vomiting
- ❑ burning

Is there anything you do that starts the pain?

_____

❑ Yes ❑ No Do you have days when the pain is so bad that you spend the whole day in bed?

How often do you take medicine for the relief of pain?
- ❑ every day
- ❑ frequently
- ❑ occasionally
- ❑ seldom
- ❑ never

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017 HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do YOU believe is the cause of your pain or condition? _____

- ❑ Injury to the jaw
- ❑ Injury to the neck
- ❑ Injury to the head
- ❑ Injury to the back
- ❑ Orthodontic treatment
- ❑ Excessively large bite or yawn
- ❑ Irregular or raised dental filling
- ❑ Dental treatment or extraction
- ❑ Excessive opening of mouth
- ❑ Cervical traction
- ❑ Whiplash injury
- ❑ Other: _____
- ❑ On its own; can't relate the onset to anything specific
- ❑ Jaw or nose broken
- ❑ Head or neck surgery
- ❑ Motor vehicle accident
- ❑ Motorcycle accident
- ❑ Severe emotional upset
- ❑ Work-related incident
- ❑ Athletic endeavor
- ❑ Illness
- ❑ Fight
- ❑ Injury
- ❑ Playground incident
- ❑ Fall
- ❑ Accident - Date:_____

Is there anything that makes your pain or discomfort worse? _____

Is there anything that makes your pain or discomfort better? _____

What other information is important to your pain or condition?_____

_____