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 SPECIFIC SYMPTOMS

❑ Check if head, neck, back and jaw joints are currently without pain or discomfort *(skip this section and section 012)*

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?
❑ Yes ❑ No Teeth grinding

EAR RELATED CONDITIONS

❑L ❑R ❑B Buzzing in the ears
❑L ❑R ❑B Tinnitus (ringing in the ears)
❑L ❑R ❑B Ear pain
❑L ❑R ❑B Ear stuffiness
❑L ❑R ❑B Pain in front of the ear
❑L ❑R ❑B Pain behind the ear
❑L ❑R ❑B Hearing loss

SYMPTOMS (continued)

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 ears

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 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
❑ Yes ❑ No Thyroid enlargement
❑ Yes ❑ No Tightness in throat
❑ Yes ❑ No Tingling in the hands or fingers
❑ Yes ❑ No Chronic sinusitis

Other: _____

_____

_____

012 HEAD PAIN HISTORY

ORIGIN AND NATURE

Did the symptoms start after any of the following?
(Choose ONE from below)

❑ 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
❑ Severe emotional upset
❑ Cervical traction
❑ Whiplash injury
❑ Jaw or nose broken
❑ Head or neck surgery

Under what circumstances did the pain begin?

❑ with an accident at work
❑ with an accident at home
❑ with an accident not at home or at work
❑ at work but not involving an accident
❑ on its own; can't relate the onset to anything specific
❑ Other (describe)_____

What do you do that starts the pain or makes it worse?

_____

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

How would you describe the type(s) of pain you experience?
(Choose ONE from below)

❑ sharp
❑ dull
❑ aching
❑ deep
❑ superficial
❑ throbbing
❑ diffused
❑ constant
❑ intermittent
❑ cyclic

How often do you take medicine for the relief of pain?

❑ every day
❑ frequently
❑ occasionally
❑ seldom
❑ never

What do YOU think is the cause of your pain?

_____

LOCATION

❑L ❑R ❑B Which side are the headaches worse? (choose ONE)

Headache spreads to (choose ONE):

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

HEAD PAIN HISTORY (continued)

ORIGIN AND NATURE

When having pain, do you experience:

- ❑ dizziness
- ❑ lightheadedness
- ❑ double-vision
- ❑ fatigue
- ❑ nausea
- ❑ forgetfulness
- ❑ sensitivity to light (photophobia)
- ❑ sensitivity to noise
- ❑ throbbing
- ❑ vomiting
- ❑ burning

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

DURATION

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

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

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

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

FREQUENCY

How frequent is your pain? (choose ONE):

❑ seldom ❑ frequent
❑ occasional ❑ every day

013 HISTORY OF SYMPTOMS

When did your condition first occur? _____

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

Pick one:

❑ Motor vehicle accident ❑ Motorcycle accident ❑ Work-related incident
❑ Athletic endeavor ❑ Illness ❑ Fight
❑ Injury ❑ Fall ❑ Playground incident
❑ Accident (Date:_____) ❑ Other: _____

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? _____

_____

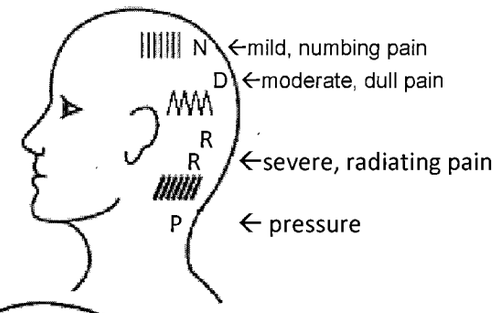
014 LIST ANY TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

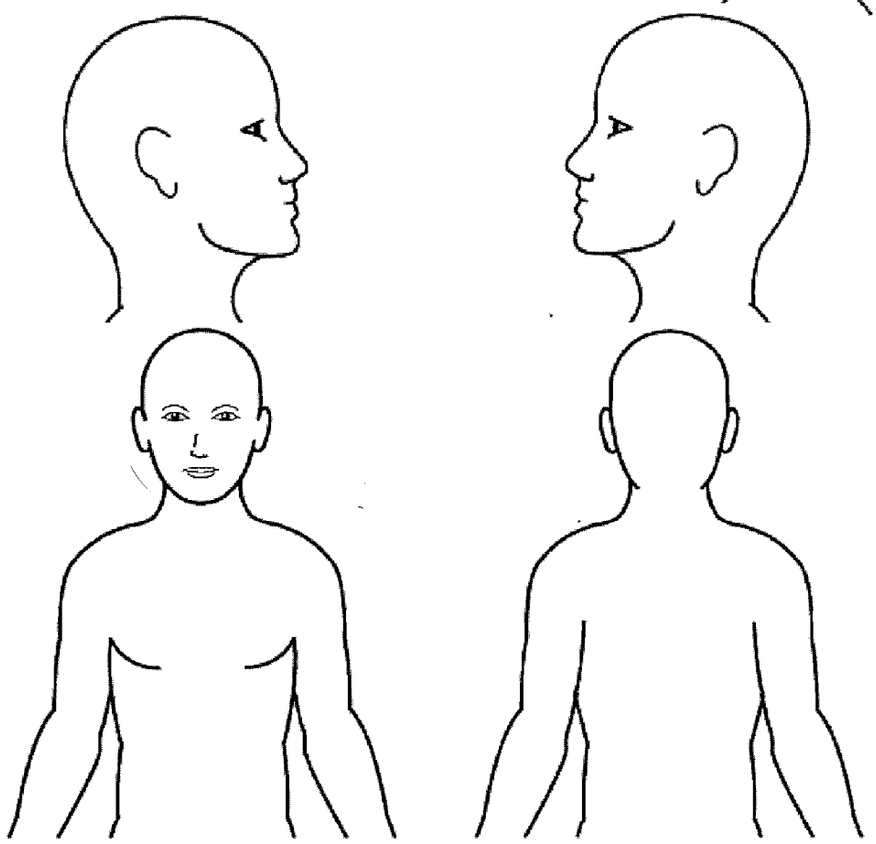
Practitioner Specialty Treatment & Approximate Date

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

015 DRAW YOUR PAIN PATTERN FOLLOWING THIS KEY:

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





016 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 ❑ Never

Snoring: (Frequency) ❑ 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 ❑ _____