

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: Do you get to sleep well, stay asleep well, and wake up feeling rested?
Bruxism
Clenching
Waking up & having difficulty sleeping
Excessive movements
Frequency of nocturnal urination (# of times) per nt.
Getting up (# of times) per night.
Awake: Awakens un-refreshed
Has morning headaches
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
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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

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

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

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

DURATION

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

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

FREQUENCY

How frequent is your pain? (choose ONE):

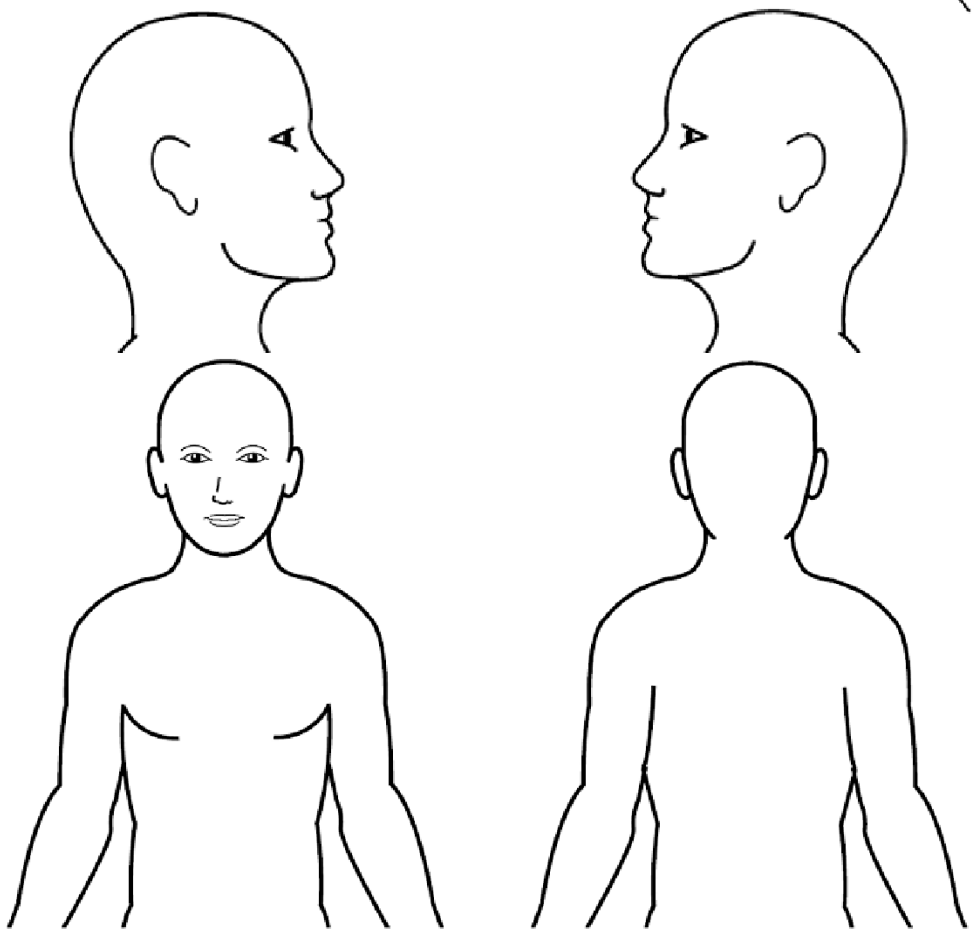
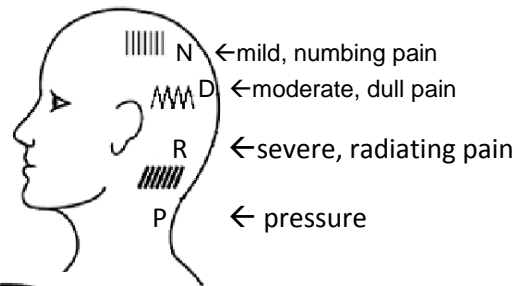
- seldom
- frequent
- occasional
- every day

015 DRAW YOUR PAIN PATTERN FOLLOWING THIS KEY:

- MILD PAIN
- MODERATE PAIN
- SEVERE PAIN

- |||||
- vvvvv
- ////////

- B = burning
- D = dull
- 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

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?

When having pain, do you experience:

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

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

- every day
- frequently
- occasionally
- seldom
- never

017 HISTORY OF SYMPTOMS

When did your condition first occur? _____

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

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