ATLANTIC PAIN CENTRE @
ATLANTIC DENTAL

Halifax Shopping Centre
7001 Mumford Road
Halifax, NS B3L 2H8

Tel: 902 453-2100
Fax: 902 453-3626
kirkblanchard@eastlink.ca

Please answer the following questions to the best of your ability. You should get as detailed as possible and add any additional information that you feel is necessary. Please bring this form with you when you come for your consultation visit. Should you have any questions about this form or your upcoming visit feel free to contact our office and we will be happy to assist you.

Please use the following list to provide information about your issues:

1. Please number (rank) your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Rate your complaints for frequency and intensity:

Frequency:
(1- Seldom, 2- Occasional, 3- Frequent, 4- Every day)

Intensity:
0= No Pain and 10 is the most severe pain.

	Rank (order of importance)	Frequency	Intensity
Snoring	____	____	____
Gasping for breath while sleeping	____	____	____
Poor quality of sleep	____	____	____
Daytime sleepiness	____	____	____
Complaints from spouse or partner	____	____	____
Morning headaches	____	____	____
Reflux / GERD	____	____	____
Jaw joint aches	____	____	____
Jaw joint noises	____	____	____
Other:			

When did you become aware of the problem?

_____

_____

Have you had the details of your sleep test explained to you? In your own words, what's your understanding of the problem/diagnosis?

_____

_____

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Who have you seen regarding this?

_____

_____

What types of tests have you had?

:_____

_____

What types of treatment have you had?

CPAP Surgery Breathing Strips Other

_____

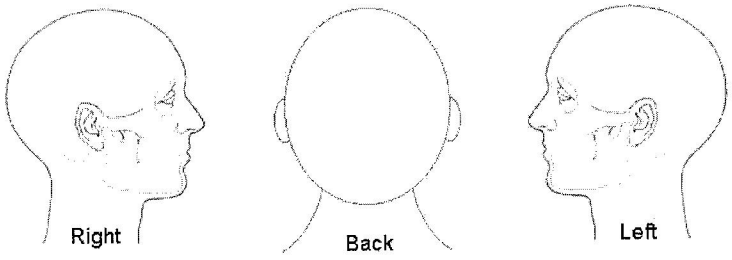
_____

Did the treatment help?

_____

_____

If you have headache or facial pain, please shade the diagram to indicate where the pain is present.



On a scale of 0-10 with 10 being the worst pain imaginable, what's your worst head pain?

_____

_____

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Please list ***all*** of the medications you currently take. Include the dosage, and when you take the pills. Please add any other information about the medication that you feel is important.

Medication Name	Dose (mg)	When do you take it? (ie. morning, evening, only when needed?)

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Do you have any tooth pain at this time?	Yes	No
Do you have sensitive teeth?	Yes	No
Do you have loose teeth?	Yes	No
Do you get sinus pain or pressure?	Yes	No
Do you get neck or back pain?	Yes	No
Do you have any allergies? (products or medications)	Yes	No
If yes, please list _____		
Do you have a bleeding disorder, or do you bleed or bruise easily?	Yes	No
Do you have any liver disease?	Yes	No
Do you have any lung disease or difficulty breathing?	Yes	No
Are you aware of any snoring?	Yes	No
Do you ever gasp for breath in your sleep?	Yes	No
Have you taken cortisone or steroids (please circle lotion or pill)?	Yes	No
Have you ever had heart surgery or heart disease?	Yes	No
Do you have any conditions involving your heart or blood pressure?	Yes	No
Do you have any kidney disease?	Yes	No
Have you had cancer or chemotherapy or radiation treatment?	Yes	No
If yes, how long ago? _____		
Have you had an organ transplant?	Yes	No
If yes, what organ? _____		
Are you taking anti-rejection medication?	Yes	No
Are you diabetic?	Yes	No
If yes, do you take pills or insulin?		
Other than the above, have you been hospitalized and was surgery performed?	Yes	No
Have you had any serious illness?	Yes	No
Do you have any other medical conditions?	Yes	No
Women: Are you pregnant? If yes, what month? _____	Yes	No
Are you breast feeding?	Yes	No
Do you take birth control pills	Yes	No
Which pill and for how long?		

Other Comments:

_____

_____

_____

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To better coordinate your treatment it is required that you list the professionals including all physicians, dentists, and therapists (massage therapists, physiotherapists) that you have consulted concerning your symptoms. In addition please list your general physician and family dentist (if not at this clinic). If your present symptoms are a result of an accident and you are working with an attorney please list that attorney as well. Include addresses whenever possible.

Doctor: _____ Address: _____ _____ Phone: _____	Dentist: _____ Address: _____ _____ Phone: _____
Name: _____ Address: _____ _____ Phone: _____	Name: _____ Address: _____ _____ Phone: _____
Name: _____ Address: _____ _____ Phone: _____	Name: _____ Address: _____ _____ Phone: _____
Name: _____ Address: _____ _____ Phone: _____	Name: _____ Address: _____ _____ Phone: _____

I understand that the professionals I have listed above may be sent information regarding my diagnosis and treatment.

Signature:_____ Date: _____