DENTA4

Form A - Symptoms Form

Patient Form | Phone: 1 (604) - 777 - 1337

Name | Birthdate | Date | Gender ☐ Male ☐ Female

Please check any of the following symptoms you may have:

Designate severity of Pain and/or Discomfort: 1 = mild, 2 = moderate, 3 = sever

Head/Face			
Forehead	☐ 1	☐ 2	☐ 3
Temporal	☐ 1	☐ 2	☐ 3
Tension headaches	☐ 1	☐ 2	☐ 3
Migraine headaches	☐ 1	☐ 2	☐ 3
Sinus headaches	☐ 1	☐ 2	☐ 3
Back of head headaches	☐ 1	☐ 2	☐ 3
Hair scalp tender to touch	☐ 1	☐ 2	☐ 3
Ear			
Ear pain without infection	☐ 1	☐ 2	☐ 3
Decreased hearing	☐ 1	☐ 2	☐ 3
itchy or stuff y	☐ 1	☐ 2	☐ 3
Dizziness	☐ 1	☐ 2	☐ 3
Balance problems	☐ 1	☐ 2	☐ 3
Throat			
Swallowing difficulties	☐ 1	☐ 2	☐ 3
Feeling of foreign object in throat	☐ 1	☐ 2	☐ 3
Sore throat without infection	☐ 1	☐ 2	☐ 3
Voice changes	☐ 1	☐ 2	☐ 3
Laryngitis	☐ 1	☐ 2	☐ 3
Frequent coughing or clearing	☐ 1	☐ 2	☐ 3
Jaw			
Jaw pain	☐ 1	☐ 2	☐ 3
Jaw joint pain	☐ 1	☐ 2	☐ 3
Clicking/popping jaw joint	☐ 1	☐ 2	☐ 3
Grating sound in jaw joint	☐ 1	☐ 2	☐ 3
Pain in cheek muscles	☐ 1	☐ 2	☐ 3
Uncontrollable jaw movements	☐ 1	☐ 2	☐ 3
Jaw locks open/shut	☐ 1	☐ 2	☐ 3
Deviates to one side on opening or closing	☐ 1	☐ 2	☐ 3

Eyes	☐ 1	☐ 2	☐ 3
Pain in/around eyes	☐ 1	☐ 2	☐ 3
Bloodshot eyes	☐ 1	☐ 2	☐ 3
Sensitive to light	☐ 1	☐ 2	☐ 3
Tearing of eyes	☐ 1	☐ 2	☐ 3
Blurred vision	☐ 1	☐ 2	☐ 3
Pressure behind eyes	☐ 1	☐ 2	☐ 3
Neck			
Lack of mobility	☐ 1	☐ 2	☐ 3
Stiffness	☐ 1	☐ 2	☐ 3
Neck pain	☐ 1	☐ 2	☐ 3
Tired/sore neck muscles	☐ 1	☐ 2	☐ 3
Shoulder pain	☐ 1	☐ 2	☐ 3
Arm/finger pain/numbness	☐ 1	☐ 2	☐ 3
Mouth	☐ 1	☐ 2	☐ 3
Abnormal opening	☐ 1	☐ 2	☐ 3
Limited opening	☐ 1	☐ 2	☐ 3
Bad bite	☐ 1	☐ 2	☐ 3
Missing teeth	☐ 1	☐ 2	☐ 3
Excessive mouth breathing	☐ 1	☐ 2	☐ 3
Clench or grind teeth	☐ 1	☐ 2	☐ 3
Mouth discomfort	☐ 1	☐ 2	☐ 3
Inability to fi nd “bite”	☐ 1	☐ 2	☐ 3

☐ I am interested in learning more how the doctor can help my Pain and/or Discomfort