

Pain History Questionnaire

Marking Instructions

- Use black or blue pen or a number 2 pencil
- Do not use pens with ink that soaks through the paper
- Circle the appropriate answer to each question
- Make no stray marks
- Let us know if you are not able to understand any question

General and Oral Health

1. Would you say your health in general is excellent, very good, good, fair or poor?

1	2	3	4	5
Excellent	Very good	Good	Fair	Poor

2. How good a job do you feel you are doing in taking care of your health overall?

1	2	3	4	5
Excellent	Very good	Good	Fair	Poor

3. Would you say your oral health in general is excellent, very good, good, fair or poor?

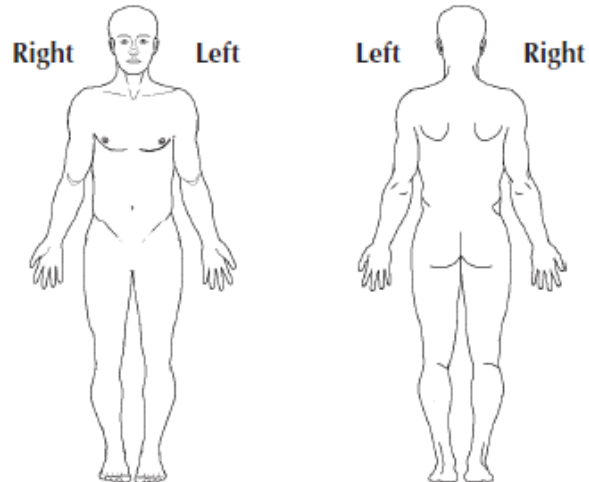
1	2	3	4	5
Excellent	Very good	Good	Fair	Poor

4. How good a job do you feel you are doing in taking care of your oral health?

1	2	3	4	5
Excellent	Very good	Good	Fair	Poor

Bodily Symptoms

5. On the diagram, shade in the areas where you feel pain. Please put an X on the area that hurts the most.



6. a. Do you have rheumatoid arthritis, lupus, or other systemic arthritic disease?

0	1
No	Yes

6.b. Do you know of anyone in your family who has had any of these diseases in question 6a?

0	1
No	Yes

6.c. Have you had or do you have any swollen or painful joint(s) other than the joints in front of your ears (TMJ)?

0	1
No	Yes

[If no swollen or painful joints, SKIP to question 7.]

If Yes,

6.d. Is this a persistent pain which you have had for at least one year?

0	1
No	Yes

7. In the last month, how much have you been distressed by. . .

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
a. Headaches	0	1	2	3	4
c. Faintness or dizziness	0	1	2	3	4
d. Pains in the heart or chest	0	1	2	3	4
e. Feeling low in energy or slowed down	0	1	2	3	4
j. Pains in the lower back	0	1	2	3	4
p. Soreness of your muscles	0	1	2	3	4
r. Trouble getting your breath	0	1	2	3	4
s. Hot or cold spells	0	1	2	3	4
t. Numbness or tingling in parts of your body	0	1	2	3	4
u. A lump in your throat	0	1	2	3	4
w. Feeling weak in parts of your body	0	1	2	3	4
x. Heavy feelings in your arms or legs	0	1	2	3	4

Head/Jaw Symptoms

8. Have you had pain in the face, jaw, temple, in front of the ear or in the ear in the past month?

0	1
No	Yes

9.a. Have you ever had your jaw lock or catch so that it won't open all the way?

0	1
No	Yes

[If no problem opening all the way, SKIP to question 10a]

If Yes,

9.b. Was this limitation in jaw opening severe enough to interfere with your ability to eat?

0	1
No	Yes

10.a. Have you had a recent injury to your face or jaw?

0	1
No	Yes

[If no recent injuries, SKIP to question 11]

If Yes,

10.b. Did you have jaw pain before the injury?

0	1
No	Yes

11. During the last six months have you had a problem with headaches or migraines?

0	1
No	Yes

12. What activities does any current jaw problem prevent or limit you from doing?

a. Chewing	0	1
	No	Yes

b. Drinking	0	1
	No	Yes

c. Exercising	0	1
	No	Yes

d. Eating hard foods	0	1
	No	Yes

e. Eating soft foods	0	1
	No	Yes

f. Smiling/laughing	0	1
	No	Yes

g. Sexual activity	0	1
	No	Yes

h. Cleaning teeth or face	0	1
	No	Yes

i. Yawning	0 No	1 Yes
j. Swallowing	0 No	1 Yes
k. Talking	0 No	1 Yes
l. Having your usual facial appearance	0 No	1 Yes

Demographic Information

13. When were you born?

Month ___ Day ___ Year ___

14. Are you male or female?

1 2
Male Female

15. Which of the following groups best represent your ethnicity?

Hispanic or Latino 1
NonHispanic or Latino 2

16. Which of the following groups best represent your race?

Aleut, Eskimo or American Indian 1
Asian or Pacific Islander 2
Black 3
White 4
Other (Please specify) _____ 5

17. What is the highest grade or year of regular school that you have completed?

Never attended or Kindergarten: 0 0
Elementary School: 1 2 3 4 5 6 7 8
High School: 9 10 11 12
College: 13 14 15 16 17
More than 18 18

18. a. During the past 2 weeks, did you work at a job or business not counting work around the house (include unpaid work in the family farm/business)?

0	1
No	Yes

(If yes, skip to question 19)

If no,

18. b. Even though you did not work during the past 2 weeks, did you have a job or business?

0	1
No	Yes

(If yes, skip to question 19)

If no,

18. c. Were you looking for work or on layoff from a job during those 2 weeks?

Yes, looking for work	1
Yes, lay off	2
Yes, both on layoff and looking for job	3
No	4

19. Are you married, widowed, divorced, separated or never been married?

Married-spouse in household	1
Married-spouse not in household	2
Widowed	3
Divorced	4
Separated	5
Never Married	6
Significant other- in household	7
Significant other- not in household	8

20. Which of the following best represents your total combined household income during the past 12 months?

Less than \$10,000	1
\$10,000 to \$19,999	2
\$20,000 to \$29,999	3
\$30,000 to \$39,999	4
\$40,000 to \$49,999	5
\$50,000 to \$59,999	6
\$60,000 to \$69,999	7
\$70,000 to \$79,999	8
\$80,000 or more	9

Diagnosis of Persistent RCT Pain

PI: Donald Nixdorf

Participant Number: # _____

HSC: XXXXXXXXXXXXXXX

Oral Health Impact Profile - 14

INSTRUCTIONS

THE QUESTIONNAIRE.

This questionnaire asks how troubles with your teeth, mouth or dentures may have caused problems in your daily life. We would like you to complete the questionnaire even if you have good dental health. We would like to know how often you have had each of the 14 listed problems during the LAST YEAR.

HOW TO ANSWER THE QUESTIONS.

Each question on the left hand side of the page asks you about a particular dental problem. You should think about each question in turn, and circle the answer to the right of the question, to indicate how often you have had the problem during the last year.

EXAMPLES

If you occasionally had painful aching in your mouth, you would circle the answer as shown in this example.

3. Have you had painful aching in your mouth? VERY FAIRLY **OCCAS-** HARDLY NEVER DON'T
OFTEN OFTEN IONALLY EVER KNOW

If you have never had the problem during the last year, circle "NEVER" as follows.

3. Have you had painful aching in your mouth? VERY FAIRLY OCCAS- HARDLY **NEVER** DON'T
OFTEN OFTEN IONALLY EVER KNOW

<p>HOW OFTEN have you had the problem during the last year? (circle your answer)</p>
--

1.	Have you had trouble <u>pronouncing any words</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
2.	Have you felt that your <u>sense of taste</u> has worsened because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
3.	Have you had <u>painful aching</u> in your mouth?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
4.	Have you found it <u>uncomfortable to eat any foods</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
5.	Have you been <u>self conscious</u> because of your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
6.	Have you <u>felt tense</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
7.	Has your <u>diet been unsatisfactory</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
8.	Have you had to <u>interrupt meals</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
9.	Have you found it <u>difficult to relax</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW
10.	Have you been a bit <u>embarrassed</u> because of problems with your teeth, mouth or dentures?	VERY OFTEN	FAIRLY OFTEN	OCCAS- IONALLY	HARDLY EVER	NEVER	DON'T KNOW

Continued next page...

HOW OFTEN have you had the problem during the last year?
(circle your answer)

- | | | | | | | |
|---|---------------|-----------------|-------------------|----------------|-------|---------------|
| 11. Have you been a bit <u>irritable with other people</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
| 12. Have you had <u>difficulty doing your usual jobs</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
| 13. Have you felt that life in general was <u>less satisfying</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |
| 14. Have you been <u>totally unable to function</u> because of problems with your teeth, mouth or dentures? | VERY
OFTEN | FAIRLY
OFTEN | OCCAS-
IONALLY | HARDLY
EVER | NEVER | DON'T
KNOW |

Please write today's date

____ / ____ / ____
 month day year

Diagnosis of Persistent RCT Pain

PI: Donald Nixdorf

Participant Number: # _____

HSC: XXXXXX

Date: ____/____/____

Hospital Anxiety and Depression Scale (HADS)

1. I feel tense or "wound up."
 - a. Most of the time 3
 - b. A lot of the time 2
 - c. From time to time, occasionally 1
 - d. Not at all 0

2. I still enjoy the things I used to enjoy.
 - a. Definitely as much 0
 - b. Not quite as much 1
 - c. Only a little 2
 - d. Hardly at all 3

3. I get a sort of frightened feeling as if something awful is about to happen.
 - a. Very definitely and quite badly 3
 - b. Yes, but not too badly 2
 - c. A little, but it doesn't worry me 1
 - d. Not at all 0

4. I can laugh and see the funny side of things.
 - a. As much as I always could 0
 - b. Not quite so much now 1
 - c. Definitely not so much now 2
 - d. Not at all 3

5. Worrying thoughts go through my mind.
 - a. A great deal of the time 3
 - b. A lot of the time 2
 - c. From time to time but not too often 1
 - d. Only occasionally 0

6. I feel cheerful.
 - a. Not at all 3
 - b. Not often 2
 - c. Sometimes 1
 - d. Most of the time 0

7. I can sit at ease and feel relaxed.
 - a. Definitely 0
 - b. Usually 1
 - c. Not often 2
 - d. Not at all 3

Diagnosis of Persistent RCT Pain

PI: Donald Nixdorf

Participant Number: # _____

HSC: XXXXXX

Date: ____/____/____

8. I feel as if I am slowed down.
- a. Nearly all the time 3
 - b. Very often 2
 - c. Sometimes 1
 - d. Not at all 0
9. I get a sort of frightened feeling like "butterflies" in the stomach.
- a. Not at all 0
 - b. Occasionally 1
 - c. Quite often 2
 - d. Very often 3
10. I have lost interest in my appearance.
- a. Definitely 3
 - b. I don't take so much care as I should 2
 - c. I may not take quite as much care 1
 - d. I take just as much care as ever 0
11. I feel restless as if I have to be on the move. R
- a. Very much indeed 3
 - b. Quite a lot 2
 - c. Not very much 1
 - d. Not at all 0
12. I look forward with enjoyment to things.
- a. As much as I ever did 0
 - b. Rather less than I used to 1
 - c. Definitely less than I used to 2
 - d. Hardly at all 3
13. I get sudden feelings of panic.
- a. Very often indeed 3
 - b. Quite often 2
 - c. Not very often 1
 - d. Not at all 0
14. I can enjoy a good book or radio or TV program.
- a. Often 0
 - b. Sometimes 1
 - c. Not often 2
 - d. Very seldom 3

Diagnosis of Persistent RCT Pain

1 of 2

PI: Donald Nixdorf

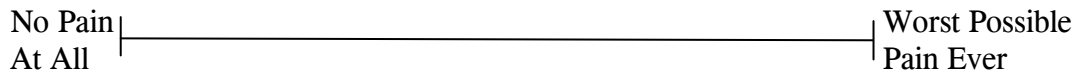
Participant Number: # _____

Date: ____/____/____

Please choose the words below that describe your pain *now*. If a word does not describe your pain, choose the 0 (*none*) for that word. For each word that does describe your pain, rate the intensity for that quality of your pain marking under the appropriate descriptor (*mild, moderate or severe*).

	<u>NONE</u>	<u>MILD</u>	<u>MODERATE</u>	<u>SEVERE</u>
THROBBING	0) _____	1) _____	2) _____	3) _____
SHOOTING	0) _____	1) _____	2) _____	3) _____
STABBING	0) _____	1) _____	2) _____	3) _____
SHARP	0) _____	1) _____	2) _____	3) _____
CRAMPING	0) _____	1) _____	2) _____	3) _____
GNAWING	0) _____	1) _____	2) _____	3) _____
HOT-BURNING	0) _____	1) _____	2) _____	3) _____
ACHING	0) _____	1) _____	2) _____	3) _____
HEAVY	0) _____	1) _____	2) _____	3) _____
TENDER	0) _____	1) _____	2) _____	3) _____
SPLITTING	0) _____	1) _____	2) _____	3) _____
TIRING-EXHAUSTING	0) _____	1) _____	2) _____	3) _____
SICKENING	0) _____	1) _____	2) _____	3) _____
FEARFUL	0) _____	1) _____	2) _____	3) _____
PUNISHING-CRUEL	0) _____	1) _____	2) _____	3) _____

Rate the intensity of your pain on the two scales below. Make a mark on the line to indicate where your pain falls between *No Pain* and *Worst Possible Pain Ever* and then circle the appropriate number on the second scale.



- 0 NO PAIN
- 1 MILD
- 2 DISCOMFORTING
- 3 DISTRESSING

Diagnosis of Persistent RCT Pain

2 of 2

PI: Donald Nixdorf

Participant Number: # _____

Date: ____/____/____

4 EXCRUCIATING

Patient Name _____ Date _____

This pain scale can help to determine whether the nerves that are carrying your pain signals are working normally or not. It is important to find this out in case different treatments are needed to control your pain.

.....
A. PAIN QUESTIONNAIRE

- . Think about how your tooth, gum or mouth pain has felt over the last week.
- . Please say whether any of the descriptions match your pain exactly, by circling yes or no for each question.

1) Does your pain feel like strange, unpleasant sensations in your tooth, gum or mouth? Words like pricking, tingling, pins and needles might describe these sensations.

No - My pain doesn't really feel like this

Yes - I get these sensations quite a lot

2) Does your pain make your gum or mouth in the painful area look different from normal? Words like mottled or looking more red or pink might describe the appearance.

No - My pain doesn't affect the color of my gum or mouth

Yes - I've noticed that the pain does make my gum or mouth look different from normal

3) Does your pain make the affected tooth, gum or mouth region abnormally sensitive to touch? Getting unpleasant sensations when lightly stroking the tooth, gum or mouth region, or getting pain when food touches that area inside your mouth might describe the abnormal sensitivity.

No - My pain doesn't make my tooth, gum or mouth abnormally sensitive in that area

Yes - My skin seems abnormally sensitive to touch in that area

4a) Does your pain come on suddenly and in bursts for no apparent reason when you're still? Words like electric shock, jumping and bursting describe these sensations.

No - My pain doesn't really feel like this

Yes - I get these sensations quite a lot

4b) On about how many days have you had tooth, gum or mouth pain in the past 6 months? (Every day = 180 days) _____

5) Does your pain feel as if the temperature in the painful area has changed abnormally? Words like hot and burning describe these sensations.

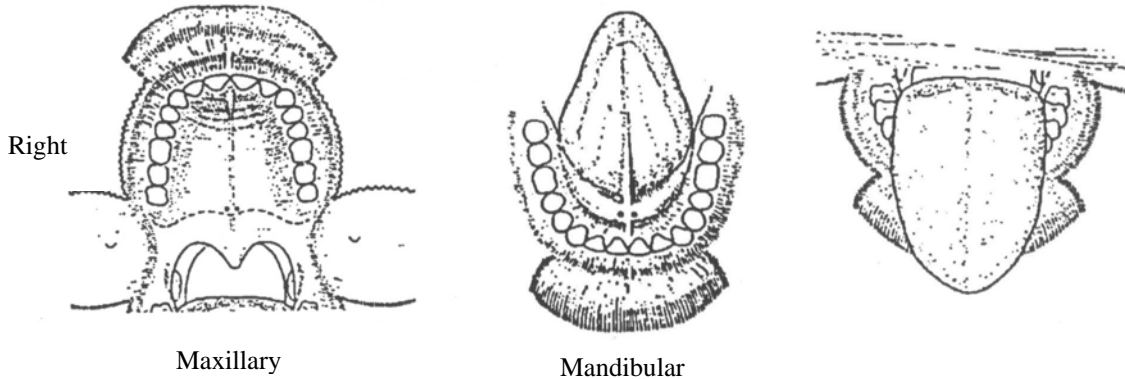
No - I don't really get these sensations

Yes - I get these sensations quite a lot

STOP HERE

B. INTRAORAL SENSORY TESTING to be completed by dentist

Tooth, gingiva or mucosa-associated pain sensitivity can be examined by comparing the painful area with a contralateral or adjacent non-painful area for the presence of allodynia and an altered pin-prick threshold (PPT). First, have the patient outline their suspected intraoral pain condition inside their mouth with a cotton swab. Indicate the painful site below with a “P” and the control site with “C”.



ALLODYNIA

Examine the response to lightly stroking the cotton swab across the non-painful area and then the painful area. If normal sensations are experienced in the non-painful site, but pain or unpleasant sensations (tingling, nausea) are experienced in the painful area when stroking, allodynia is present.

- a) No, normal sensation in both areas
- b) Yes, allodynia in painful area only

1) ALTERED PIN-PRICK THRESHOLD

Determine the pin-prick threshold by comparing the response to the Shepard’s hook end of a sharp dental explorer placed gently on to the mucosa (or gingival) in a non-painful and then painful areas. Inform the patient, **“I will now perform a simple test to check how the nerves in your tooth or gum (or skin inside your mouth) are working. I will first touch an area inside your mouth that is not painful, and then touch the painful area, and ask you how it feels to you”**. [Place the explorer onto the mucosa or gingiva]. **“How does this feel?”** If a sharp pin prick is felt in the non-painful area, but a different sensation is experienced in the painful area e.g. none/ blunt only (raised PPT) or a very painful sensation (lowered PPT), an altered PPT is present.

- a) No, equal sensation in both areas
- b) Yes, either more painful or none/blunt sensation in painful area

SCORING:

Add values in parentheses for sensory description and examination findings to obtain overall score.

TOTAL SCORE (maximum 24)

If score < 12, neuropathic mechanisms are **unlikely** to be contributing to the patient’s pain
If score ≥ 12, neuropathic mechanisms are **likely** to be contributing to the patient’s pain

Diagnosis of Persistent RCT Pain

PI: Donald Nixdorf

Participant Number: # _____

HSC: XXXXXXXXXX

Date: ____/____/____

Jaw Functional Limitation Scale

For each of the items below, please indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then circle '10'.

		No Limitation						Severe Limitation					
		0	1	2	3	4	5	6	7	8	9	10	
1.	Chew tough food	0	1	2	3	4	5	6	7	8	9	10	
2.	Chew chicken (e.g., prepared in oven)	0	1	2	3	4	5	6	7	8	9	10	
3.	Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food)	0	1	2	3	4	5	6	7	8	9	10	
4.	Open wide enough to drink from a cup	0	1	2	3	4	5	6	7	8	9	10	
5.	Swallow	0	1	2	3	4	5	6	7	8	9	10	
6.	Yawn	0	1	2	3	4	5	6	7	8	9	10	
7.	Talk	0	1	2	3	4	5	6	7	8	9	10	
8.	Smile	0	1	2	3	4	5	6	7	8	9	10	