TRIGEMINAL NEURALGIA ASSOCIATION
FACE PAIN SURVEY

Select a 4-digit Unique ID Number: ☐☐☐☐

Today's Date: ________________________

SECTION I: CONTACT INFORMATION

First Name:		MI:		Last Name:		Gender: ☐M / ☐F
Address:						
City:		ST:		Postal Code:		
Country:						

Daytime Phone:	( ) -
Evening Phone:	( ) -
FAX Number:	( ) -
E-Mail Address:	
Date of Birth:	/ /

SECTION II: PRESENT DIAGNOSIS

(Some people have more than one disorder. Check any that you've had and indicate if you are pain free now).

☐Trigeminal Neuralgia
☐Atypical Trigeminal Neuralgia
☐Glossopharyngeal Neuralgia
☐Occipital Pain or Neuralgia
☐Temporomandibular Joint Disorder
☐Multiple Sclerosis
☐Atypical Facial Pain (ATFP)
☐Other
☐I am pain-free at present

SECTION III: FAMILY AND PERSONAL HISTORY

Has anyone in your family had any of the following conditions? (If no, please skip to your medical history)

☐Facial Spasm
☐Seizure
☐Neurofibromatosis
☐Trigeminal Neuralgia
☐Migraine
☐Aneurysm
☐Multiple Sclerosis
☐Brain Tumor

Which relatives?

☐Father ☐Mother ☐Sibling ☐Cousin ☐Grandfather ☐Grandmother ☐Other

SECTION IV: YOUR MEDICAL HISTORY

Have you ever been told by a doctor that you have any of the following? (check all that apply)

☐High Blood Pressure
☐Migraine
☐Fibromyalgia/Myofascial Pain
☐Other Headache Syndrome
☐Seizure / Epilepsy
☐Stroke
☐Multiple Sclerosis
☐Chicken Pox
☐Cold Sores / Herpes
☐Mononucleosis
☐Sinus Problems
☐TMJ Disorder
☐Diabetes
☐Lupus
☐Arthritis
☐Benign Brain Tumor

Before your face pain developed, did you have a root canal or other dental therapy? ☐Yes ☐No

If "Yes", how many: _____days / _____weeks / _____ months before your face pain?

When did pain first develop in your face? Year: ________ Your Age Then: ________

Please describe your pain when it first started: (check all that apply)

Type of Pain: ☐ Aching ☐ Throbbing ☐ Prolonged, Burning Pain ☐ Repeated, Electric Shock Jabs

How Often: ☐ Constant ☐ Several Times Per Day ☐ Several Times Per Week ☐ A Few Times Per Month ☐ Less Frequent

Which Sides Were Affected: ☐ Left Side ☐ Right Side ☐ Both

Did Pain Awaken You From Sleep: ☐ Yes ☐ No

Please write in the intensity for each area affected: (on a scale of 1 = Slight Discomfort, to 10 = Very intense, overwhelming pain)

	Forehead or Temple		In the Ear		Joint of the Jaw		Throat
	Cheek		Upper Jaw		Specific Tooth		Neck
	In or "behind" Eye		Lower Jaw		Tongue or Roof of Mouth		Back of Head

Have you had pain in the past year? ☐ Yes ☐ No

If "Yes", please describe your pain: (check all that apply)

Type of Pain: ☐ Aching ☐ Throbbing ☐ Prolonged, Burning Pain ☐ Repeated, Electric Shock Jabs

How Often: ☐ Constant ☐ Several Times Per Day ☐ Several Times Per Week ☐ A Few Times Per Month ☐ Less Frequent

Which Sides Are Affected: ☐ Left Side ☐ Right Side ☐ Both

Does Pain Awaken You From Sleep: ☐ Yes ☐ No

Please write in the intensity for each area affected: (on a scale of 1 = Slight Discomfort, to 10 = Very intense, overwhelming pain)

	Forehead or Temple		In the Ear		Joint of the Jaw		Throat
	Cheek		Upper Jaw		Specific Tooth		Neck
	In or "behind" Eye		Lower Jaw		Tongue or Roof of Mouth		Back of Head

SECTION V: FINDING HELP FOR YOUR DISORDER

How long did it take to get a diagnosis? _______ #Months _______ #Years

What kinds of caregivers did you see *before* you were diagnosed with TN, ATN, GN, or ATFP? (check "X" for all that apply)

☐ Dentist ☐ Oral Surgeon ☐ Neurosurgeon ☐ Endodontist
☐ Neurologist ☐ Ophthalmologist ☐ Ear-Nose-Throat Specialist ☐ Pain Specialist
☐ Psychiatrist/Psychologist ☐ Chiropractor ☐ Doctor (General Practitioner)

Were you ever incorrectly diagnosed? ☐ No ☐ Yes If Yes, how many times? ___________

What incorrect diagnoses did you receive? (Please check all that apply – SKIP if you had no problems getting a diagnosis.)

☐ Abscessed tooth (root canal or extraction) ☐ Bite/Occlusion problem ☐ Psychological Problem
☐ Tooth Problem (other than abscess) ☐ Headache/Migraine ☐ Addiction Problem

☐ Gum Problem
☐ TMJ Problem
☐ Allergy Problem
☐ Sinus Problem
☐ Chiropractic Dislocation
☐ ________________________

What kind of caregiver first told you that your symptoms might be related to TN, ATN, GN, or ATFP?

☐ Dentist
☐ Neurologist
☐ Psychiatrist/Psychologist
☐ Oral Surgeon
☐ Ophthalmologist
☐ Chiropractor
☐ Neurosurgeon
☐ Ear-Nose-Throat Specialist
☐ Doctor (General Practitioner)
☐ Endodontist
☐ Pain Specialist

SECTION VI: DRUG TREATMENTS YOU RECEIVED

Write in how much of your pain was relieved by each drug you've used: **1**= No Relief, **2**= Partial Relief, **3**= Pain Gone
Enter dates most frequently used. If you didn't use a drug, leave blank.

Relief	Drug Treatment	Month / Year Start	Month / Year End
	Carbamazepine (Tegretol)	/	/
	Gabapentine (Neurontin)	/	/
	Ibuprofen, Advil (NSAIDS	/	/
	Ms contin (Morphine Sulfate)	/	/
	Misoprostol (Cytotec	/	/
	Baclofen (Lioresal)	/	/
	Phenytoin (Dilantin)	/	/
	Fluoxetine (Prozac, Seronil)	/	/
	Oxycodone (Percodan / cet)	/	/
	Sumatriptan	/	/
	Clonazepam (Rivatril, Klonopin)	/	/
	Oxcarbazepine (Trileptal)	/	/
	Amitriptyline (Triptyl, Elavil)	/	/
	Codeine	/	/
	Pimozide (Orap)	/	/

List your current or most recent medications:

____

____

For the most recent medications, if you had side effects, what were they?

☐ Check here if you had no side effects

Write in the severity of each effect, on a scale of 1=mild, 2=moderate, 3=severe, 4=very severe

☐ Rash
☐ Poor Attention Span
☐ Liver Toxicity
☐ Nausea
☐ Memory Loss
☐ Dizzy
☐ Felt Like A Zombie
☐ Tired
☐ Low Blood Count

Have you discontinued medications because of side effects? ☐ No ☐ Yes
If Yes, which drugs:

____

____

Satisfaction with most recent drug treatment (X)	☐ Very Satisfied	☐ Somewhat Satisfied	☐ Outcome Acceptable	☐ Somewhat Dissatisfied	☐ Very Dissatisfied

SECTION VII: SURGICAL TREATMENTS

If you had a surgery more than once, please indicate *how many times*. Give the most recent date you had that kind of surgery. For side effects, indicate 1= mild, 2= moderate, 3=severe, 4=very severe. Please indicate how long relief lasted.

#	Type of Surgery	Year	Pain Worse	No Change	Partial Relief	Pain Free	Side Effects	How Long Did Relief Last?	
								#Months	#Years
	Microvascular Decompression		☐	☐	☐	☐			
	Partial Surgical Sensory Rhizotomy		☐	☐	☐	☐			
	Surgical Cutting of Nerve		☐	☐	☐	☐			
	Radiofrequency Rhizotomy		☐	☐	☐	☐			
	Glycerol Rhizotomy		☐	☐	☐	☐			
	Balloon Compression		☐	☐	☐	☐			
	Gamma Knife		☐	☐	☐	☐			
	Linear Accelerator		☐	☐	☐	☐			
	Nerve Block (Injections)		☐	☐	☐	☐			
	Neuroectomy		☐	☐	☐	☐			
	Other? ___________________________		☐	☐	☐	☐			

Why did you select your most recent surgery?

- ☐ I was desperate
- ☐ My doctor does only this procedure
- ☐ Doctor recommended as best alternative for pain relief
- ☐ Doctor recommended as safest
- ☐ I got a second doctor's opinion
- ☐ I heard of another patient's successful outcome
- ☐ Based on my own research

Did you feel pressured by your doctor to have the recommended surgery? ☐ Yes ☐ No

For your *most recent* surgical treatment, if you had side effects, what were they?
☐ Check here if you had NO side effects.

Write the severity for each you had: 1=mild, 2=moderate, 3=severe, 4=very severe. Leave blank if effect did not occur

	Pain		Face Stiff		Face Numb		Anesthesia Dolorosa
	Dizzy		Memory Loss		Cloudy or Double Vision		Headache
	Painful Scar		Hearing Damage/Loss		CSF Leak		Uneven Gait
	Paralysis		Stroke				

Satisfaction with Surgeon Follow Up Care (X)	☐ Very Satisfied	☐ Somewhat Satisfied	☐ Outcome Acceptable	☐ Somewhat Dissatisfied	☐ Very Dissatisfied

SECTION VIII: RECOMMENDATIONS

Would you recommend a physician who treated you to other face pain patients? ☐ Yes ☐ No

If Yes, please give physician information:

First Name:	
Last Name:	
City:	
State:	

SECTION IX: COMMENTS

Return completed survey to:

Trigeminal Neuralgia Association
2801 SW Archer Road, Suite C
Gainesville, FL 32608