# MIRIAM GRUSHKA M.Sc., D.D.S., Ph.D.

CERTIFIED SPECIALIST IN ORAL MEDICINE (ONTARIO, BRITISH COLUMBIA)
DIPLOMATE, AMERICAN BOARD OF ORAL MEDICINE, AMERICAN BOARD OF OROFACIAL PAIN
ADJUNCT VISITING LECTURER, TUFTS UNIVERSITY, DEPARTMENT OF ORAL MEDICINE

*974 Eglinton Avenue West Toronto, ON M6C 2C5*
*Tel. (416) 787-2930 Fax (416) 656-8328*


Name: _____ _____ Title: Mr/Ms/Mrs/Miss
LAST FIRST

Address: _____ Unit/Apt # _____

City: _____ Postal Code: _____

Telephone Home: _____ Health card No: _____

Business: _____ Version Code: _____

Other: _____ Email Address: _____

Date of Birth: _____ Occupation: _____
DAY / MONTH / YEAR

AGE: _____ Place of birth, if not Canada. _____

**Referred by:** Dentist ☐ Physician ☐ Other ☐ _____

## CONSULT NOTES TO BE SENT TO:

**Family MD** Name: _____ Tel. _____ Fax _____

Address: _____ City: _____ PC _____

**Family Dentist** Name: _____ Tel. _____ Fax _____

Address: _____ City: _____ PC _____

**Specialists:** Name: _____ Specialty: _____ Tel: _____

Name: _____ Specialty: _____ Tel: _____

**Pharmacy** Name: _____ Fax _____ Tel. _____

***Do you have dental insurance coverage?*** **YES** ☐ **NO** ☐

**Insurance Company:** _____

Although the office of Dr. Miriam Grushka does not bill the insurance company directly, we will be happy to provide you with insurance forms for the amount paid after each visit.

_____
Signature

## DENTAL HISTORY

Tell me about the *dentistry, dental surgery, implants, root canal treatments* that you have had completed recently.

_____

_____

How frequently do you see your dentist? _____

Have you had local anesthetic at the dentist? **Yes** **No** Any Adverse Reactions? _____

## CONFIDENTIAL MEDICAL HISTORY

| | YES | NO | |
|---|---|---|---|
| Are you on medication? | | | *If yes, please list on next page* |
| Are you allergic to any medication? | | | |
| Are you allergic to any food or have any other allergies? | | | |
| Do you have respiratory problems or asthma? | | | |
| Do you bruise easily or have prolonged bleeding? | | | |
| Do you experience shortness of breath or chest pain? | | | |
| Have you had an injury to your face, head or jaw? | | | |
| Have you had major surgery? | | | |
| Are you pregnant? | | | |
| Do you have dry mouth? | | | |
| Do you have burning mouth pain? *Please rate below.* | | | |
|  ⇦ ***Circle level of burning mouth pain*** | | | |
| Do you have recurrent mouth sores/canker sores? | | | |
| Do your gums bleed easily | | | |
| Do you smoke? | | | |

### Have you been treated for the following?

| | YES | NO | Notes | | YES | NO | Notes |
|---|---|---|---|---|---|---|---|
| Rheumatic Fever | | | | Cancer | | | |
| Lung Disease | | | | If yes, Radiotherapy | | | |
| Heart Murmur | | | | Chemotherapy | | | |
| High Blood Pressure | | | | Glaucoma/Eye Issues | | | |
| Heart Disease/ Pacemaker | | | | Blood Disorders | | | |
| Heart Attack | | | | Emphysema/Bronchitis | | | |
| Nervous Disorders | | | | Drug/alcohol dependency | | | |
| Thyroid Problems | | | | Diabetes | | | |
| Stroke | | | | High Cholesterol | | | |
| Liver/kidney disease | | | | Fainting | | | |
| Jaundice | | | | Stomach Ulcers/Reflux | | | |
| Tuberculosis | | | | Epilepsy | | | |
| Joint Replacement | | | | Arthritis | | | |

**Have you tested <u>positive</u> for:** Hepatitis A/B/C Yes No HIV (AIDS) Yes No

**Are there any other medical concerns we should be aware of?** _____

**The above information is complete to the best of my knowledge and I have not omitted any pertinent information.**

_____ _____ _____

Signature Date Dentist's Signature

**MEDICATIONS**

| Medication | Purpose of Medication | Date |
|---|---|---|
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**Please continue next page. Thank you! ⇨**

## QUESTIONNAIRE

*Where several symptoms are mentioned please circle those which best apply to you.*

| Ear | Past | Present | Never |
|---|---|---|---|
| Do you ever have earaches? ***left*** / ***right*** | | | |
| Do you notice a buzzing, ringing, or whooshing noise in the ears? | | | |
| Do you notice a loss of hearing? | | | |
| Do you notice a fullness or stuffiness in the ears? | | | |
| **Neck and Shoulder** | | | |
| Do you ever have stiff neck or shoulders? | | | |
| Do you have ***upper*** or ***lower*** back problems? | | | |
| Do you have joint pains elsewhere in the body? ***hands*** / ***hips*** / ***knees/ other*****:** | | | |
| **Headache** | | | |
| Do you have ***frequent*** / ***severe*** headaches? | | | |
| **TM joints** | | | |
| Do you have clicking or popping noises on opening or closing your mouth or chewing? ***left*** / ***right*** | | | |
| Does your jaw ever lock partially or fully open? | | | |
| Are your jaws sore or stiff when you wake up? | | | |
| Does your discomfort or pain increase as you open your mouth? | | | |
| Do you have difficulty making your teeth fit together? | | | |
| Do you clench or grind your teeth? ***night*** / ***day*** | | | |
| Is it difficult to chew hard foods? | | | |
| Have you had any orthodontic treatment? | | | |
| Do you have any facial pain or discomfort? | | | |
| Do you have tooth pain or discomfort? | | | |

| Other | YES | NO |
|---|---|---|
| Are you sleeping well? | | |
| Have you experienced any recent facial traumas? | | |
| If so, are they as a result of a motor vehicle accident? | | |
| Are you under any unusual stress? | | |

**GAD-7**

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Worrying too much about different things | 0 | 1 | 2 | 3 |
| Trouble relaxing | 0 | 1 | 2 | 3 |
| Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| **For office: Total Score:** | | | | |

**FOR TM JOINT, JAW PAIN ONLY**

**Mandibular Function Impairment Questionnaire (MFIQ)**

**Please assign each category a score from 1-4 based on the possible answers.**

| Due to complaints about your jaw, how much difficulty do you have with | | Possible answers | i |
|---|---|---|---|
| 1. Social activities | | No difficulty | 0 |
| 2. Speaking | | A little difficulty | 1 |
| 3. Taking a large bite | | Quite a bit of difficulty | 2 |
| 4. Chewing hard food | | Much difficulty | 3 |
| 5. Chewing soft food | | Very difficult or impossible without help | 4 |
| 6. Work and/or daily activities | | | |
| 7. Drinking | | | |
| 8. Laughing | | | |
| 9. Chewing resistant food | | | |
| 10. Yawning | | | |
| 11. Kissing | | | |
| Eating food includes taking a bite, chewing, and swallowing. How much difficulty do you have with eating: | | | |
| 12. A hard cookie | | | |
| 13. Meat | | | |
| 14. A raw carrot | | | |
| 15. French bread | | | |
| 16. Peanut/almonds | | | |
| 17. An apple | | | |
| **For Office Use Only: SUM** | | | |

Item score i (0-4)
Number of items N
Sum item score S
Raw component score C =S/4N

Calculation of level of function impairment

| i | C | FIRS |
|---|---|---|
| all < 2 | ≤ 0.3 | 0 |
| one ≥ 2 | | 1 |
| all < 3 | 0.3 - 0.6 | 2 |
| one ≥ 3 | | 3 |
| all ≠ 4 | > 0.6 | 4 |
| one = 4 | | 5 |

Qualitative level of functional impairment

| Level | | FIRS |
|---|---|---|
| I | Low | 0 or 1 |
| II | Moderate | 2 or 3 |
| III | Severe | 4 or 5 |

**MIRIAM GRUSHKA**, MSC, DDS, PHD
Diplomate, American Board of Oral Medicine, American Board of Orofacial Pain
Certified Specialist in Oral Medicine (British Columbia)
Courtesy Associate Professor (Dentistry), University of Florida

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# Authorization

## to Release/Disclose or Obtain Medical Records

Your Name _____ Date of Birth _____

I, the undersigned, hereby authorize Dr. Miriam Grushka to disclose/release or obtain ***ALL*** medical notes and records. This shall include, but is not limited to, X-rays and X-ray reports, pathological reports, surgical reports, radiographic reports, lab reports, diagnostic results, prognosis reports, medical reports, progress notes, and consultation notes.

I fully understand this Authorization and Request to Release or Obtain Records and Information from my records as to the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I have had the opportunity to ask and have had answered any questions regarding these records. I release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnoses, treatment, and similar topics relevant to the above listed purposes for this release of records.

**I authorize Dr. Grushka to use my information anonymously for the purpose of conducting retrospective (chart review) research.**

**I understand that I can withdraw my consent to use my information for research at any time.**

○ **YES**

○ **NO**

Signature of Patient _____ Date _____

Witness _____ Date _____