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

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.

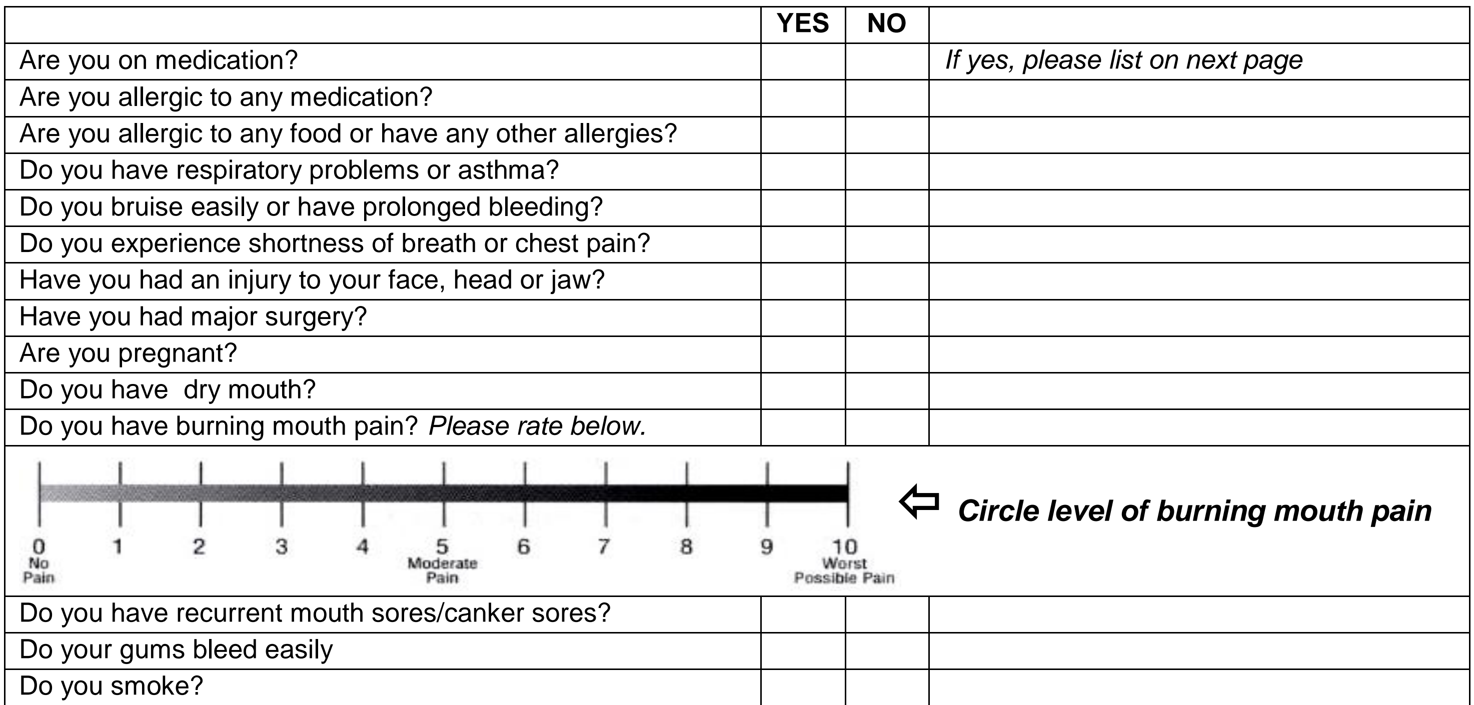
____

____

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.*			
0 No Pain — 1 — 2 — 3 — 4 — 5 Moderate Pain — 6 — 7 — 8 — 9 — 10 Worst Possible Pain			⇦ ***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 positive 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

Please continue next page. Thank you! ⇨

QUESTIONNAIRE

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

	Past	Present	Never
Do you ever have earaches? ***left*** / ***right***			
Do you notice a buzzing, ringing, or whooshing noise in the ears? ***frequently*** / ***occasionally*** / ***rarely***			
Do you notice a loss of hearing?			
Do you notice a fullness or stuffiness in the ears?			
Do you feel a loss of balance?			
Do you ever feel dizzy / black out temporarily?			

	Past	Present	Never
Do you ever have stiff neck or shoulders? ***frequently*** / ***occasionally***			
Do you have ***upper*** or ***lower*** back problems?			
Do you have aching or pain in your arms / ***legs***? ***left*** / ***right***			
Do you have joint pains elsewhere in the body? ***hands*** / ***hips*** / ***knees/ other*****:**			
Do you suffer from ***rheumatoid arthritis*** / ***osteoarthritis***?			

	Past	Present	Never
Do you have ***frequent*** / ***severe*** headaches? (***right*** / ***left*** / ***front*** / ***back*** of head)			
Are the headaches ***dull*** / ***sharp*** / ***throbbing*** / ***piercing***?			
Are the headaches worse when you are lying down?			
Do you have numbness of the face or head?			

	Past	Present	Never
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?			

	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? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Epworth Sleepiness scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

SITUATION	CHANCE OF DOZING (0–3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

SCORE RESULTS:

1-6	Congratulations, you are getting enough sleep!
7-8	Your score is average
9 and up	Very sleepy and should seek medical advice

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