MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

Facial pain

Structured history, interpretation & clinical review

Symptom 4 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

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> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

Facial pain is separated by attack duration, triggers, sensory loss, autonomic features, and dental, sinus, ocular, or systemic clues.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person’s usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. “Not sure” is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for Facial pain

1A. Immediate safety screen

Is there new face droop, one-sided weakness or numbness, difficulty speaking or understanding, double vision, or severe loss of coordination?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now and record the exact time the person was last known well.

Is there new confusion, reduced consciousness, a seizure, or difficulty awakening?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now. Do not leave the person alone or give food, drink, or medication by mouth.

Is there new severe breathlessness, inability to swallow saliva, blue lips, or rapidly worsening weakness?

☐ No ☐ Yes ☐ Not sure

If Yes: Call emergency services now; breathing and swallowing problems can become critical quickly.

Is there sudden loss of vision, a new missing visual field, or a painful red eye?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency eye or emergency-department assessment now.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which pain description fits best?

☐ Brief electric-shock or stabbing attacks ☐ Persistent burning or aching ☐ Pressure or fullness ☐ Throbbing or vascular-type pain

What reliably triggers the pain?

☐ Light touch, chewing, speaking, or cold air ☐ Jaw movement or chewing ☐ Eye movement or light ☐ Spontaneous, no consistent trigger

Is facial sensation altered between attacks?

☐ Sensation feels normal ☐ Persistent numbness or reduced feeling ☐ Tingling or variable sensitivity ☐ Not sure

Where is the pain?

☐ Strictly one side ☐ Both sides or midline ☐ It changes sides ☐ Not sure

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person's baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Triggerable unilateral shock-like attacks

Which pain description fits best? Brief electric-shock or stabbing attacks
What reliably triggers the pain? Light touch, chewing, speaking, or cold air
Where is the pain? Strictly one side

Prompt clinical review pattern — Promptly

Touch-triggered unilateral electric attacks follow the trigeminal pathway.

Differential to review:

- Trigeminal neuralgia or trigeminal neuropathy
- Dental, temporomandibular, or sinus disorder

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Contingency: Arrange neurological assessment; persistent facial numbness or another cranial-nerve abnormality increases the need for urgent structural evaluation.

Pattern 2: Facial pain with persistent sensory loss

Is facial sensation altered between attacks? Persistent numbness or reduced feeling

Urgent assessment pattern — Same day

Persistent facial numbness moves the pathway from typical neuralgia toward trigeminal neuropathy or a structural lesion.

Differential to review:

- Trigeminal neuralgia or trigeminal neuropathy
- Giant cell arteritis, ocular, or other inflammatory disorder

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 3: Jaw or local structural pattern

What reliably triggers the pain? Jaw movement or chewing
Which pain description fits best? Pressure or fullness / Persistent burning or aching

Structured clinical review pattern — Routine review

Chewing-linked pain warrants dental or jaw assessment while neurological warning signs are screened.

Differential to review:

- Dental, temporomandibular, or sinus disorder
- Persistent idiopathic facial pain or migraine-related facial pain

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Trigeminal neuralgia or trigeminal neuropathy

Discriminating features: Short unilateral shock-like attacks triggered by innocuous touch support neuralgia; persistent sensory loss suggests neuropathy or a structural cause.

Logical investigations: Cranial-nerve examination; clinician-directed MRI of the trigeminal pathway, especially with sensory loss, atypical age, bilateral symptoms, or abnormal signs.

3.2 Dental, temporomandibular, or sinus disorder

Discriminating features: Chewing-triggered, pressure-like, dental, or jaw-associated pain requires local structural assessment.

Logical investigations: Dental/ENT examination as indicated; avoid attributing persistent focal neurological findings to a local cause without examination.

3.3 Persistent idiopathic facial pain or migraine-related facial pain

Discriminating features: Persistent daily pain without a clear local lesion, or attacks with migraine-associated features.

Logical investigations: Full cranial-nerve, dental, and headache assessment; review phenotype and prior imaging rather than assuming a primary pain disorder.

3.4 Giant cell arteritis, ocular, or other inflammatory disorder

Discriminating features: Jaw claudication, scalp tenderness, visual symptoms, painful eye movements, or systemic inflammation.

Logical investigations: Urgent inflammatory-marker and specialist evaluation when temporal-arteritis features occur; eye findings require urgent ophthalmic assessment.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127

Madison Neurology LLC — Neurology Symptom Guide
Facial pain — including electric-shock-like or touch-triggered pain
Educational reference only. Not for clinical use. Treatment is outside the scope of this workbook.