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TMJ PATIENT HISTORY FORM

Date: Date of Birth:
Name: Dr. Mr. Mrs. Ms. Miss
Address:
City: State/Province: Zip/Postal Code:
Referred by:

MAJOR REASON FOR CURRENT EVALUATION:

1) Describe what you think the problem is:
2) What do you think caused this problem?:
3) Describe, in order (first to last), what you expect from your treatment:

GENERAL HISTORY:

(Check here for us to refer back to your health history form if we already have the information needed in # 's 1-4)

1) Are you presently under the care of a physician or have you been in the past year? YES NO
   Physicians name:
   Treatment:
   Name of medication(s) you are currently taking:
2) How would you describe your overall physical health?: (circle one)
   Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
3) How would you describe your dental health?: (circle one)
   Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent
   Dentist's name: Date of last visit:
4) Have you ever had any major dental treatment in the last two years?: YES NO
   Please check procedure(s).: Orthodontics Periodontics Oral Surgery Restorative
   Date(s) of Third Molar (wisdom tooth) extraction(s):
5) Do you have, or have you ever had, Arthritis or any other bone problems?: YES NO
   If yes, please explain.:
6) Have you had any sprains or problems with any joints or ligaments?: YES NO
   If yes, please explain.:

FACIAL INJURY/TRAUMA HISTORY:

1) Is there any childhood history of falls, accidents or injury to the face or head? Describe:
2) Is there any recent history of trauma to the head or face? (Car accident or any facial impact)
   Describe:
3) Do you participate in any activity that holds the head or jaw in an imbalanced position? (Phone, swimming, musical instrument) Describe:

TMJ TREATMENT HISTORY:

1) Have you ever been examined for a TMJ problem before?: YES NO
   If yes, by whom?: When:
2) What was the nature of the problem? (Pain, noise, limitation of movement, etc.):
3) What was the duration of the problem?: Month(s) Years
   Or is this a new problem?: Yes No
4) Is the problem getting better, worse or staying the same?:
5) Have you ever had physical therapy for TMJ?: YES NO
   If yes, by whom?: When?:

6) Have you ever received treatment for jaw problems?: ☐ YES ☐ NO
If yes, by whom?: _____ When: _____
What was the treatment?:
☐ Bite Splint ☐ Medication ☐ Physical Therapy ☐ Occlusal Adjustment ☐ Orthodontics ☐ Surgery
7) Was treatment effective?: ☐ YES ☐ NO

CURRENT MEDICATIONS:

1) Degree of current TMJ pain: (circle one)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain
2) Frequency of TMJ Pain: ☐ Daily ☐ Weekly ☐ Monthly ☐ Semi-Annually
3) Are you taking any medication for the TMJ problem? ☐ YES ☐ NO
If yes, what kind?: _____
4) Are you aware of anything that makes your pain worse?: ☐ YES ☐ NO
If yes, what?: _____
5) Does your jaw make noise? ☐ YES ☐ NO
RIGHT ☐ Clicking ☐ Popping ☐ Grinding Other: _____
LEFT ☐ Clicking ☐ Popping ☐ Grinding Other: _____
6) Does your jaw lock open? ☐ YES ☐ NO When did this first occur?: _____
7) Has your jaw ever locked closed of partially closed?: ☐ YES ☐ NO
When did this first occur?: _____
8) Do you do anything now to relieve your pain for your TMJ issue?: ☐ YES ☐ NO
9) Is there any additional information that can help us in this area?:
_____

HABIT HISTORY:

1) Do you sleep with an unusual head position?: ☐ YES ☐ NO
2) Are you aware of any habits or activities that may aggravate this condition?: ☐ YES ☐ NO
Describe: _____
3) Do you consider yourself to be under more stress than most people?: ☐ YES ☐ NO
4) Do you clench your teeth together under stress?: ☐ YES ☐ NO

SYMPTOMS: (Check each symptom that applies)

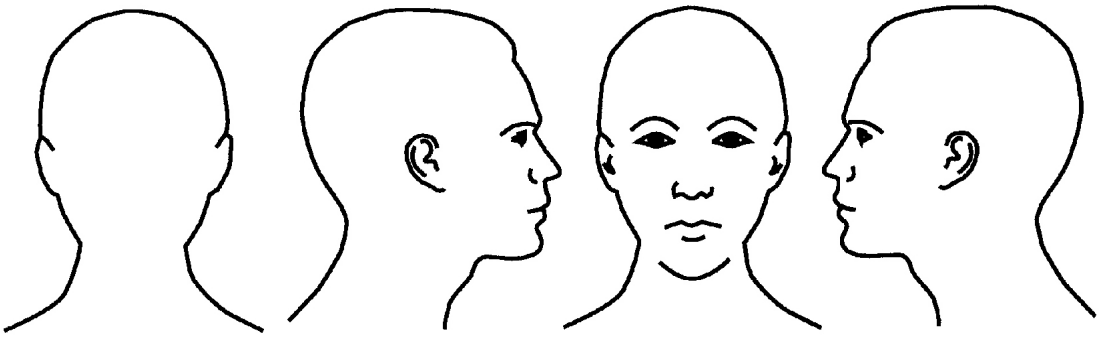
☐ Jaw Pain
☐ Eye Pain
☐ Neck Pain
☐ Pain on Opening Mouth
☐ Pain on Chewing
☐ Limitation of Jaw Movement
☐ Ear Pain
☐ Face Pain
☐ Headaches

IF YOU HAVE PAIN, IS THE PAIN:

☐ Constant
☐ Intermittent
☐ Stabbing
☐ Burning
☐ Shooting
☐ Throbbing
☐ Increasing
☐ Dull
☐ Sharp
☐ Other: _____

1) Do you know what brings on the pain? If yes, please explain.: _____
2) If you have pain, is the intensity: ☐ Slight ☐ Moderate ☐ Severe
3) When is the pain most severe?:
☐ Morning ☐ Midday
☐ Afternoon ☐ Night
4) Do you clench or grind your teeth?: ☐ YES ☐ NO If yes: ☐ During the day ☐ At night
5) Are your teeth sore or sensitive?: _____
6) Do you have difficulty or discomfort?
☐ Talking?: _____ ☐ Swallowing?: _____

On the figures below, mark and "X" where you have pain. Circle the "X" where the pain is most severe.



RIGHT **LEFT**

Please use the space below to provide any additional comments or concerns that you may have regarding TMJ:

PATIENT SIGNATURE: DATE: