HISTORY FORM FOR PATIENT WITH TEMPOROMANDIBULAR DISORDER

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:

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

	Poor				Average				Excellent			Enter #
2) How would you describe your overall physical health?	0	1	2	3	4	5	6	7	8	9	10	
3) How would you describe your dental health?	0	1	2	3	4	5	6	7	8	9	10	

   Dentist's name Date of last appointment
4) Have you ever had any major dental treatment in the last two years? YES NO
   If yes, please check procedure(s) Orthodontics Periodontics Oral Surgery Restorative
   Date(s) of Third Molar (wisdom tooth) extraction(s)

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 of face? (Auto accident, sports injury, facial impact)
   Describe:
3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)
   Describe:

TMD TREATMENT HISTORY:

1) Have you ever been examined for a TMD problem before? YES NO
   If yes, by whom? When?
2) What was the nature of the problem? (Pain, noise, limitation of movement)
3) What was the duration of the problem? Months Years 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 TMD? 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? (Please check below)
   Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics Counseling Surgery
   Other (Please explain)

CURRENT MEDICATIONS/APPLIANCES:

	No Pain				Moderate Pain				Severe Pain			Enter#
1) Degree of current TMD pain:	0	1	2	3	4	5	6	7	8	9	10	

2) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually
   Is there a pattern related to pain occurrence? Upon Waking Morning Afternoon Evening After Eating
4) Are you taking medication for the TMD problem? If so, what type?
5) Are you aware of anything that makes your pain worse? YES NO If yes what?

6) Does your jaw make noise? YES NO
RIGHT Clicking Popping Grinding Other
LEFT Clicking Popping Grinding Other
7) Does your jaw lock open? YES NO When did this first occur?
8) Has your jaw ever locked closed or partly closed? YES NO
Whe did this first occur?
9) Have any dental appliances been prescribed? YES NO
If yes by whom?
Describe
10) Are these appliances effective? YES NO
11) Is there any additional information that can help us in this area?

CURRENT STRESS FACTORS: (Please check each factor that applies to you)

Death of Spouse
Business Adjustment
Financial Problems
Fired from Work
Death of Family Member
Marital Seperation
Major Illness or Injury
Divorce
Pregnancy
Marital Reconciliation
New Person Joins Family
Major Health Change in Family
Pending Marriage
Career Change
Taking on Debt
Other

HABIT HISTORY: (Check your answer to each question)

1) Do you clench your teeth together under stress? YES NO DON'T KNOW
2) Do you grind/clench your teeth at night? YES NO DON'T KNOW
3) Do you sleep with an unusual head position? YES NO DON'T KNOW
4) Are you aware of any habits or activities that may aggravate this condition? YES NO DON'T KNOW
Describe

SYMPTOMS: (Check each symptom that applies)

A. HEAD PAIN, HEADACHES, FACIAL PAIN
Forehead L R
Temples L R
Migraine Type Headaches
Cluster Headaches
Maxillary Sinus Headaches (under the eyes)
Occipital Headaches (back of the head with or without shooting pain)
Hair and/or Scalp Painful to Touch

B. EYE PAIN OR EAR ORBITAL PROBLEMS
Eye Pain – Above, Below or Behind
Bloodshot Eyes
Blurring of Vision
Bulging Appearance
Pressure Behind the Eyes
Light Sensitivity
Watering of the Eyes
Drooping of the Eyelids

C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS
Discomfort
Limited Opening
Inability to Open Smoothly

D. TEETH AND GUM PROBLEMS
Clenching, Grinding at Night
Looseness and/or Soreness of Back Teeth
Tooth Pain

E. JAW & JAW JOINT (TMD) PROBLEMS
Clicking, Popping Jaw Joints
Grating Sounds
Jaw Locking Opened or Closed
Pain in Cheek Muscles
Uncontrollable Jaw/Tongue Movements

F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES
Hissing, Buzzing, Ringing or Roaring Sounds
Ear Pain without Infection
Clogged, Stuffy, Itchy Ears
Balance Problems – "Vertigo"

G. OTHER PAIN
If so, please describe:

H. THROAT PROBLEMS
Swallowing Difficulties
Tightness of Throat
Sore Throat
Voice Fluctuations
Laryngitis
Frequent Coughing/Clearing Throat
Feeling of Foreign Object in Throat
Tongue Pain
Salivation
Pain in the Hard Palate

I. NECK AND SHOULDER PAIN
Reduced Mobility and Range of Motion
Stiffness
Neck Pain
Tired, Sore Neck Muscles
Back Pain, Upper and Lower Shoulder

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