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
Physician's name _____ Condition treated _____
Treatment _____
Name of medication(s) you are currently taking _____
Poor Average Excellent
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 had any major dental treatment in the last two years? YES NO
If yes, please circle 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 or 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 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 circle below)
Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics
Counseling Surgery Other (Please explain) _____
_____

CURRENT MEDICATIONS/APPLIANCES

No Pain Moderate Pain Sever Pain

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
3) Are you taking medication for the TMD problem? If so, what type? _____
How long? _____ Who prescribed the medication _____
4) Are the medications that you take effective? YES NO Conditional _____
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
When did this first occur? _____ How often? _____
9) Have any dental appliances been prescribed? YES NO
If yes, by whom? _____ When? _____
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 [ ] Major Illnesses or Injury [ ] Major Health Change in Family
[ ] Business Adjustment [ ] Divorce [ ] Pending Marriage
[ ] Financial Problems [ ] Pregnancy [ ] Career Change
[ ] Fired from Work [ ] Marital Reconciliation [ ] Taking on Debt
[ ] Death of Family Member [ ] New Person Joins the Family [ ] Other
[ ] Marital Separation

HABIT HISTORY: (Circle 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 the condition?
YES NO DON'T KNOW

Describe _____

SYMPTOMS: (Circle 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 Ears
- Light Sensitivity
- Watering of the Eyes
- Drooping of the Eyelids

C. MOUTH, FACE, CHEEK & 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 AND JAW JOINT (TMD) PROBLEMS IMBALANCES
- Clicking, Popping Jaw Joints
- Grating Sounds
- Jaw Locking Opened or Closed
- Pain in Cheek Muscles
- Uncontrollable Jaw/Tongue Movements

F. PAIN, EAR PROBLEMS, POSTURAL
- Hissing, Buzzing, Ringing or Roaring Sounds
- Ear Pain without Infection
- Clogged, Stuffy, Itchy Eyes
- Balance Problems - "Vertigo"
- Diminished Hearing

G. OTHER PAIN

If so, please describe:

_____
_____
_____
_____

H. THROAT PROBLEMS
- Swallowing Difficulties
- Tightness of Throat
- Sore Throat
- Voice Fluctuations
- Laryngitis
- Frequent Coughing/Clearing of 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 Aches
- Arm and Finger Tingling, Numbness, Pain

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