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: ______________

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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 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 circle below)
Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics Counseling Surgery
Other (Please explain) ______________

CURRENT MEDICATIONS/APPLIANCES:

	No Pain	Moderate Pain	Severe 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? ______________

(CONTINUED ON REVERSE SIDE)

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? ____________ How often? ________
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? ________________
Describe ________________
10) Are these appliances effective? YES NO
11) Is there any additional information that can help us in this area? ________________
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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 Separation
[ ] 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: (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 this 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 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 AND 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"
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 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.