Date:

TMD HISTORY FORM

Patient's Name: _____
Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐
S.S.N./S.I.N.: _____
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 mark 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? ☐YES ☐NO
   Describe: _____
2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact) ☐YES ☐NO
   Describe: _____
3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument) ☐YES ☐NO
   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 mark below)
   ☐Bite Splint ☐Medication ☐Physical Therapy ☐Occlusal Adjustment ☐Orthodontics ☐Counseling ☐Surgery
   Other (Please explain) _____
7) Have you ever had injections for your TMD with muscle relaxants (BOTOX®, Flexoril) cortisone or anti-inflammatories? ☐Were they effective Yes__No__

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? ☐YES ☐NO 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?: _____ 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? _____

CURRENT STRESS FACTORS: (Please mark 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: (Please mark 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: (Please mark 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