

History Form for Patient with Temporomandibular Disorder

Date _____

Name _____ Birth date _____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems

	Left	Right	
Joint clicking or popping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Grating noises	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Jaw locks open	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Jaw locks closed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Limited jaw opening	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Jaw does not open smoothly	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Soreness of jaw joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Soreness of face muscles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____

Teeth Problems

Teeth grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Teeth clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Soreness of one or more teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Looseness of one or more teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____

Head and Facial Pain

	Left	Right	(least)	Degree of Pain	(most)
Migraine type headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
Cluster headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
Sinus headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
Headaches in back of head	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	
Hair and/or scalp painful to touch	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	

Ear or Balance Problems

Pain in ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Ringling or buzzing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Clogged or stuffy ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____
Diminished hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments _____

Dizziness or vertigo Yes No Comments _____

Poor sense of balance Yes No Comments _____

Throat Problems

Swallowing difficulty Yes No Comments _____

Throat tightness Yes No Comments _____

Throat soreness Yes No Comments _____

Laryngitis Yes No Comments _____

Voice fluctuations Yes No Comments _____

Throat congestion Yes No Comments _____

Frequent cough Yes No Comments _____

Frequent throat clearing Yes No Comments _____

Excessive salivation Yes No Comments _____

Tongue pain Yes No Comments _____

Pain in roof of mouth Yes No Comments _____

Neck and/or Shoulder Pain

Neck/shoulder/back pain Yes No Comments _____

Neck/shoulder/back reduced mobility Yes No Comments _____

Frequent neck muscle fatigue Yes No Comments _____

Arm or finger tingling, numbness, pain Yes No Comments _____

Eye Problems

Pain around or behind eyes Yes No Comments _____

Bloodshot eyes Yes No Comments _____

Blurred vision Yes No Comments _____

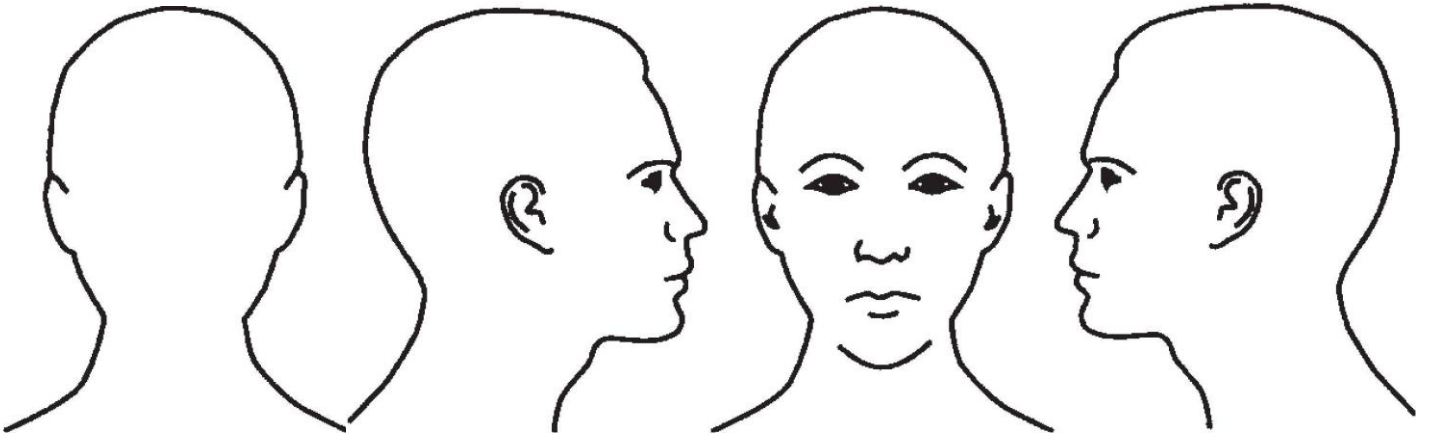
Pressure behind eyes Yes No Comments _____

Light sensitivity Yes No Comments _____

Watering of eyes Yes No Comments _____

Drooping of eyelids Yes No Comments _____

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



PATIENT HEALTH INFORMATION

Do you have any recent or childhood history of trauma to the head or face (such as falls, auto accident, blows to the head or face, sports injury)? If yes, please describe: _____

Do you have a frequent activity that causes you to hold your head or neck in an imbalanced position (such as playing instrument, keyboarding, holding phone, etc)? If yes, please describe: _____

Have you been treated for a TMD problem before? If so, when? _____ By whom? _____

Was the problem the same or different than your current problem? _____

What treatment did you have? _____

Do you think the treatment was successful? _____

What would you like your treatment here to achieve? _____

UPDATES

Updates _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Updates _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Updates _____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____