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Date _____

History Form for Temporomandibular Joint Disorder

Name _____ Date of Birth _____ Address _____

Primary Concern/ Discomfort: _____
Describe what you think the problem is: _____

Facial Injury/ Trauma History:
Is there any childhood history of falls, accidents or injury to the face or head? Describe: _____
Is there any recent history of trauma to the head or face (auto accident, sports injury, facial impact)? Describe: _____
Is there any activity which holds the head or jaw in an imbalanced position (phone, swimming, instrument)? Describe: _____

Dental/ 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? _____
7) 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: 1 2 3 4 5 6 7 8 9 10
2) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually
3) Is there a pattern related to pain occurrence? Upon waking Morning Afternoon Evening After eating
4) Are you taking medication for the TMD problem?
   a. If so, what type? _____
   b. How long? _____
   c. Who prescribed the medication? _____
5) Are the medications that you take effective? YES NO Conditional _____
6) Are you aware of anything that makes your pain worse? YES NO If yes, what? _____
7) Does your jaw make noise? YES NO What type? Clicking Popping Grinding Which side? Right Left both
8) Does your jaw lock open? YES NO How often? _____ When did this first occur? _____
9) Has your jaw ever locked closed or partly closed? YES NO How often? _____ When did this first occur? _____
10) Have any dental appliances been prescribed? YES NO If yes, by whom? _____When? _____
    Describe _____ 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)

[ ] Business adjustment	[ ] Marital separation/divorce	[ ] Major illness or injury
[ ] Financial problems	[ ] Pregnancy	[ ] Death of spouse
[ ] Fired from work	[ ] Major health changes	[ ] Death of family member
[ ] Taking on debt	[ ] Career change	[ ] Other

Habit History: (Circle your answer to each question)
I) Do you clench your teeth together under stress? ..... Yes No Uncertain
2) Do you grind/clench your teeth at night? ..... Yes No Uncertain
3) Do you sleep with an unusual head position? ..... Yes No Uncertain
4) Are you aware of any habits/activities that may aggravate this condition? Yes No Uncertain

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 eyes)
Occipital Headaches (back of the head with/ 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 & Chin Problems
Discomfort
Limited opening
Inability to open smoothly

D. Teeth & 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/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 & Shoulder pain
Reduced mobility & motion
Stiffness
Neck pain
Tired, Sore neck muscles
Back pain
Upper & lower shoulder aches
Arm & finger tingling, numbness, pain

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