

TMJ Health History Form

List previous doctors that you have seen for your **present** ailment:

Dr. _____ treatment was _____

Dr. _____ treatment was _____

Dr. _____ treatment was _____

General Health –

Have you had the following?

	YES	NO		YES	NO
Arthritis	_____	_____	Sinus Infection	_____	_____
Osteoarthritis	_____	_____	Ear Infection	_____	_____
Rheumatoid Arthritis	_____	_____	Swollen Glands	_____	_____
Blood Vessel Disease	_____	_____	Frequent Headaches	_____	_____
Neckache	_____	_____	Shoulder Pain	_____	_____
Earache	_____	_____	Ringing in Ears	_____	_____
Dizziness	_____	_____	Change in Hearing	_____	_____

Have you ever had a severe blow to the head or jaw? YES _____ NO _____

What part of your head or jaw? _____ Date _____

Do you have trouble sleeping? YES NO

Do you think you sleep too much? YES NO

Do you consider yourself to be under a great deal of stress? YES NO

Chief Complaint _____

Describe problem in your own words: _____

How long have you been bothered by this problem? _____ days, weeks, months, years

Do symptoms affect one or both sides? RIGHT LEFT BOTH (which is worse?)

Is your problem worse in the -- MORNING or NIGHT

Do you take medicine to relieve your pain or muscle spasms? YES NO SOMETIMES

What medicines do you take: _____

Is the medicine effective? YES NO

Pain Symptoms –

On the figure, outline where your pain is

Circle the kinds of pain you have – sharp, dull, aching, superficial, deep, burning, pulsating, radiating

constant, intermittent

morning, afternoon, evening

Grade your pain from 1-10 (1=painfree, 10=unbearable pain) _____

Is it difficult for you to chew? YES NO Painful to chew? YES NO

Does your pain keep you from doing anything? YES NO

If yes, what? _____

Are your teeth sore or sensitive? YES NO

Do you clench or grind your teeth? YES NO

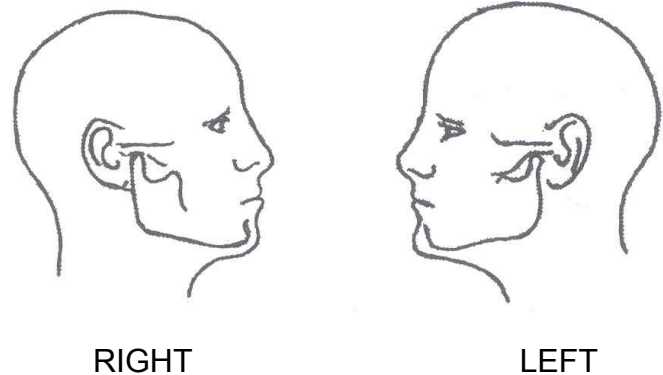
During the day? YES NO At night? YES NO

Noise –

Does your jaw make noises? YES NO

Pop _____ Click _____ Grinding _____ Other _____

When did the noise first occur? (months, years ago, etc.) _____



Can you associate a past event with the onset of the noise (trauma, dental appt., etc)? YES NO

Date of event _____

Is your jaw noise associated with pain? YES NO

Range of Motion –

Has your jaw ever locked open? YES NO locked closed? YES NO

When? _____ How often? _____

Can you open your mouth as wide as you would like? YES NO

Do you feel your jaw movements are limited? YES NO

Which movements? _____