

## 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**

	<b>Left</b>	<b>Right</b>	
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**

	<b>Left</b>	<b>Right</b>	<b>(least)</b>	<b>Degree of Pain</b>	<b>(most)</b>								
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 <u>wd</u>

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 \_\_\_\_\_

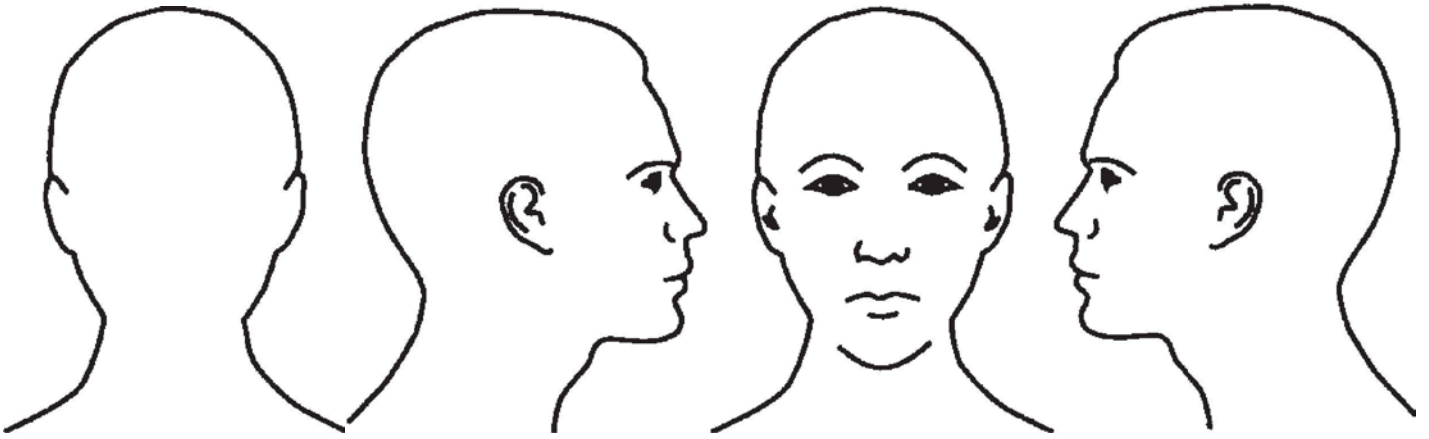
### Neck and/or Shoulder Pain

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 \_\_\_\_\_

