



HISTORY FORM FOR PATIENT WITH TEMPOROMANDIBULAR DISORDER

American Association of Orthodontists

Date _____ Date of Birth _____
 Name Dr. Mr. Mrs. Ms. Miss _____
 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
 Physicians name _____
 Treatment _____
 Name of medication(s) you are currently taking _____
- 2) How would you describe your overall physical health?

Poor	Average	Excellent	Enter #
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 ever had any major dental treatment in the last two years? YES NO
 If yes, please check 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?
 Describe: _____
- 2) Is there any recent history of trauma to the head of face? (Auto accident, sports injury, facial impact)
 Describe: _____
- 3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)
 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 check below)
 Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics Counseling Surgery
 Other (Please explain) _____

CURRENT MEDICATIONS/APPLIANCES:

- 1) Degree of current TMD pain:

No Pain	Moderate Pain	Severe Pain	Enter#
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
- 4) Are you taking medication for the TMD problem? If so, what type?
- 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?
- 8) Has your jaw ever locked closed or partly closed? YES NO
 Who did this first occur?
- 9) Have any dental appliances been prescribed? YES NO
 If yes by whom?
 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 check each factor that applies to you)

- | | | |
|------------------------|-------------------------|-------------------------------|
| Death of Spouse | Major Illness or Injury | Major Health Change in Family |
| Business Adjustment | Divorce | Pending Marriage |
| Financial Problems | Pregnancy | Career Change |
| Fired from Work | Marital Reconciliation | Taking on Debt |
| Death of Family Member | New Person Joins Family | Other |
| Marital Separation | | |

HABIT HISTORY: (Check 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: (Check each symptom that applies)

- | | | |
|--|--|--|
| <p>A. HEAD PAIN, HEADACHES, FACIAL PAIN</p> <p>Forehead L R</p> <p>Temples L R</p> <p>Migraine Type Headaches</p> <p>Cluster Headaches</p> <p>Maxillary Sinus Headaches (under the eyes)</p> <p>Occipital Headaches (back of the head with or without shooting pain)</p> <p>Hair and/or Scalp Painful to Touch</p> | <p>D. TEETH AND GUM PROBLEMS</p> <p>Clenching, Grinding at Night</p> <p>Looseness and/or Soreness of Back Teeth</p> <p>Tooth Pain</p> | <p>H. THROAT PROBLEMS</p> <p>Swallowing Difficulties</p> <p>Tightness of Throat</p> <p>Sore Throat</p> <p>Voice Fluctuations</p> <p>Laryngitis</p> <p>Frequent Coughing/Clearing Throat</p> <p>Feeling of Foreign Object in Throat</p> <p>Tongue Pain</p> <p>Salivation</p> <p>Pain in the Hard Palate</p> |
| <p>B. EYE PAIN OR EAR ORBITAL PROBLEMS</p> <p>Eye Pain – Above, Below or Behind</p> <p>Bloodshot Eyes</p> <p>Blurring of Vision</p> <p>Bulging Appearance</p> <p>Pressure Behind the Eyes</p> <p>Light Sensitivity</p> <p>Watering of the Eyes</p> <p>Drooping of the Eyelids</p> | <p>E. JAW & JAW JOINT (TMD) PROBLEMS</p> <p>Clicking, Popping Jaw Joints</p> <p>Grating Sounds</p> <p>Jaw Locking Opened or Closed</p> <p>Pain in Cheek Muscles</p> <p>Uncontrollable Jaw/Tongue Movements</p> | <p>I. NECK AND SHOULDER PAIN</p> <p>Reduced Mobility and Range of Motion</p> <p>Stiffness</p> <p>Neck Pain</p> <p>Tired, Sore Neck Muscles</p> <p>Back Pain, Upper and Lower Shoulder</p> |
| <p>C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS</p> <p>Discomfort</p> <p>Limited Opening</p> <p>Inability to Open Smoothly</p> | <p>F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES</p> <p>Hissing, Buzzing, Ringing or Roaring Sounds</p> <p>Ear Pain without Infection</p> <p>Clogged, Stuffy, Itchy Ears</p> <p>Balance Problems – “Vertigo”</p> | |
| | <p>G. OTHER PAIN</p> <p>If so, please describe:</p> | |

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

