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? _____

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?

SYMPTOMS Please mark each symptom that applies.

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

Jaw Joint Problems	**Left**		**Right**		
Joint clicking or popping	Yes	No	Yes	No	Comments:
Grating noises	Yes	No	Yes	No	Comments:
Jaw locks open	Yes	No	Yes	No	Comments:
Jaw locks closed	Yes	No	Yes	No	Comments:
Limited jaw opening	Yes	No	Yes	No	Comments:
Jaw does not open smoothly	Yes	No	Yes	No	Comments:
Soreness of jaw joints	Yes	No	Yes	No	Comments:
Soreness of face muscles	Yes	No	Yes	No	Comments:

Teeth Problems					
Teeth grinding	Yes	No	Yes	No	Comments:
Teeth clenching	Yes	No	Yes	No	Comments:
Soreness of one or more teeth	Yes	No	Yes	No	Comments:
Looseness of one or more teeth	Yes	No	Yes	No	Comments:

Ear or Balance Problems

Pain in ear	Yes	No	Comments:
Ringing or buzzing	Yes	No	Comments:
Clogged or stuffy ears	Yes	No	Comments:
Diminished hearing	Yes	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.