Eastside orthodontics

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History Form For Patient With Temporomandibular Disorder

Date: _____ Date of Birth _____

Name: Dr. Mr. Mrs. Ms. Miss _____

Address: _____

City: _____ State _____ Zip: _____

Referred by: _____

Major Reason For Current Evaluation

Describe what you think the problem is: _____

What do you think caused this problem? _____

Describe, in order (first to last), what you expect from your treatment: _____

_____

General History

Are you presently under the care of a physician or have you been in the past year? ☐ Yes ☐ No

Physician's Name: _____ Condition Treated: _____

Treatment: _____

Name of Medication(s) you are currently taking: _____

How would you describe your overall physical health? (0=poor 10 = excellent) 0 1 2 3 4 5 6 7 8 9 10

How would you describe your dental health? (0=poor 10 = excellent) 0 1 2 3 4 5 6 7 8 9 10

Dentist's Name: _____ Date of Last Appointment: _____

Have you had any major dental treatment in the last two years? ☐ Yes ☐ No

If yes, please circle procedure(s): Orthodontics Periodontics Oral Surgery Restorative

Date(s) of Third Molar (wisdom tooth) extraction(s): _____

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: _____

_____

TMD Treatment History

Have you ever been examined for a TMD problem before? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

What was the nature of the problem? (Pain, noise, limitation of movement): _____

What was the duration of the problem? [ ] Months [ ] Years Is this a new problem? ☐ Yes ☐ No

Is the problem getting better, worse, or staying the same? _____

Have you tried physical therapy for TMD? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

Current Medications/Appliances

Degree of current TMD pain? (0 = none 10 = severe) 0 1 2 3 4 5 6 7 8 9 10

Frequency of TMD pain: Daily Weekly Monthly Semi-Annually

Is there a pattern related to pain occurrence? Upon Waking Morning Afternoon Evening After Eating

Are you taking medication for the TMD problem? If so, what type? _____

How long? _____ Who Prescribed the medicine? _____

Are you aware of anything that makes your pain worse? If yes, what? _____

Does you jaw make noise? ☐ Yes ☐ No

RIGHT Clicking Popping Grinding Other _____

LEFT Clicking Popping Grinding Other _____

Does your jaw lock open? ☐ Yes ☐ No When did this first occur? _____

Have you ever locked closed or partially closed? ☐ Yes ☐ No

When did this first occur? _____ How often? _____

Have any dental appliances been prescribed? ☐ Yes ☐ No

If yes, by whom? _____ When? _____

Are these appliances effective? ☐ Yes ☐ No

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

HABIT HISTORY: (Circle your answer to each question)

Do you clench your teeth together under stress?	Yes	No	Don't know
Do you grind/clench your teeth at night?	Yes	No	Don't know
Do you sleep with an unusual head position	Yes	No	Don't know
Are you aware of any habits or activities that may aggravate the condition?	Yes	No	Don't know

Describe: _____

Symptoms

Circle each symptom that applies:

HEAD PAIN, HEADACHES, FACIAL PAIN

Forehead L R
Temples L R
Migraine Type Headaches
Cluster Headaches
Maxillary Sinus Headaches (under the eyes)
Occipital Headaches (back of the head with or without shooting pain)
Hair and/or Scalp Painful to Touch

MOUTH, FACE, CHEEK AND CHIN PROBLEMS

Discomfort
Limited Opening
Inability to Open Smoothly

JAW AND JAW JOINT (TMD) PROBLEMS IMBALANCES

Clicking, Popping Jaw Joints
Grating Sounds
Jaw Locking Opened or Closed
Pain in Cheek Muscles
Uncomfortable Jaw/Tongue Movements

OTHER PAIN

If so, please describe: _____

_____

_____

NECK AND SHOULDER PAIN

Reduced Mobility and Range of Motion
Stiffness
Neck Pain
Tired, Sore, Neck Muscles
Back Pain, Upper and Lower Shoulder Aches
Arm and Finger Tingling, Numbness, Pain

EYE PAIN OR EAR ORBITAL PROBLEMS

Eye Pain - above, below, or behind
Bloodshot Eyes
Blurring of Vision
Bulging Appearance
Pressure Behind the Ears
Light Sensitivity
Watering of the Eyes
Drooping of the Eyelids

TEETH AND GUM PROBLEMS

Clenching, Grinding at Night
Looseness and/or soreness of Back Teeth
Tooth Pain

PAIN, EAR PROBLEMS, POSTURAL

Hissing, Buzzing, Ringing or Roaring Sounds
Eat Pain without Infection
Clogged, Stuffy, Itchy Eyes
Balance Problems - "Vertigo"
Diminished Hearing

THROAT PROBLEMS

Swallowing Difficulties
Tightness of Throat
Sore Throat
Voice Fluctuations
Laryngitis
Frequent Coughing/Clearing of Throat
Feeling of Foreign Object in Throat
Tongue Pain
Salivation
Pain in the Hard Palate

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