TMJ HISTORY FORM

Do you have any problems with your jaw? Y N

If yes, please describe:

____

____

____

____

Ever received treatment for jaw problems? Y N

Who directed this treatment?

____

____

____

What was the treatment? Results?

Bite splint

Good______Fair______Poor_______

Pain medication

Good______Fair______Poor_______

Physical therapy

Good______Fair______Poor_______

Massage therapy

Good______Fair______Poor_______

Acupuncture

Good______Fair______Poor_______

Myofacial therapy

Good______Fair______Poor_______

Occlusal (bite) adjustment

Good______Fair______Poor_______

Surgery

Good______Fair______Poor_______

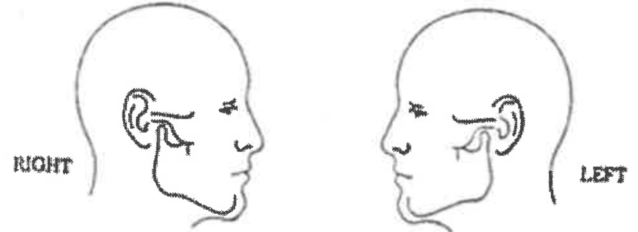
Other____

____

____

On the figures below, mark an X where you have pain.

Circle the X where pain is most intense:



When do you feel this pain?

____

____

____

Are you aware of anything that makes this pain worse?

____

____

____

Has your jaw ever locked Open? ____Closed?_____

When?____

____

Have you ever injured your jaw? Y N

When?____

____

Please provide any additional information you feel may be helpful in the diagnosis or treatment of you condition.

____

____

____

Who is your referring doctor?

____

____

Please list treating doctors:

____

____

____

____

TMJ HISTORY FORM

Name: ______________________________ **Date:** ______________________________

Do You:

Grind or clench your teeth? Y N

Use a night guard? Y N

(Circle) Hard splint (or) Soft splint? Upper (or) lower?

Brush your teeth vigorously Y N

Avoid any part of your mouth when brushing or eating?

____

____

Catch food between any of your teeth? Y N

Use dental floss daily or Waterpik? Y N

Smoke or chew tobacco? Y N

How much per day?______________________

Do you or have you ever had:

Bleeding gums? Y N

Periodontal treatments or surgeries? Y N

Orthodontics? Y N

What age/year?__________ Wear retainers? Y N

Name of Orthodontist: ______________________

Pain in and around your ears? Y N

Ringing? ____ Hearing loss? ____ Ear pressure?_____

Headache/migraines? Y N

How often?______________________

Medications:______________________

Jaw pain, clicking, popping, when you chew? Y N

Left ________ Right________ Both________

Sucked thumb or finger as a child Y N

Nail biting__________ Cheek biting__________

Sleep disorder or sleep apnea Y N

Date of sleep study______________________

Ear, nose and throat history:

Tonsillectomy Y N

Adenoids Y N

Deviated septum Y N

Sinus surgeries Y N

Tubes in ears Y N

Any swelling or lumps in your mouth Y N

Neurological disorder Y N

Trigeminal neuralgia Y N

Car accident Y N

Whiplash Y N

Neck and shoulder pain Y N

What do you think of your teeth?

____

____

____

Are you in any dental discomfort at this time?

____

____

____

Have you had recent dental work?

____

____

____

What are your dental goals?

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