



Date: \_\_\_\_\_

## HISTORY FORM FOR PATIENT WITH TEMPOROMANDIBULAR DISORDER

Patient's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female   
S.S.N./S.I.N.: \_\_\_\_\_  
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  
Physician's name: \_\_\_\_\_ Condition treated: \_\_\_\_\_  
Treatment: \_\_\_\_\_  
Name of medication(s) you are currently taking: \_\_\_\_\_
- 2) How would you describe your overall physical health? 

<b>Poor</b>	<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
<b>Average</b>											
<b>Excellent</b>											
- 3) How would you describe your dental health? 

<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
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Dentist's name: \_\_\_\_\_ Date of last appointment: \_\_\_\_\_
- 4) Have you had any major dental treatment in the last two years?  YES  NO  
If yes, please mark 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?  YES  NO  
Describe: \_\_\_\_\_
- 2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)  YES  NO  
Describe: \_\_\_\_\_
- 3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)  YES  NO  
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 mark below)  
 Bite Splint  Medication  Physical Therapy  Occlusal Adjustment  Orthodontics  Counseling  Surgery  
Other (Please explain) \_\_\_\_\_

### CURRENT MEDICATIONS/APPLIANCES:

- 1) Degree of current TMD pain: 

<b>No Pain</b>	<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
<b>Moderate Pain</b>											
<b>Severe Pain</b>											
- 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
- 3) Are you taking medication for the TMD problem?  YES  NO If so, what type? \_\_\_\_\_  
How long? \_\_\_\_\_ Who prescribed the medication? \_\_\_\_\_
- 4) Are the medications that you take effective?  YES  NO Conditional \_\_\_\_\_
- 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?: \_\_\_\_\_ How often? \_\_\_\_\_
- 8) Has your jaw ever locked closed or partly closed?  YES  NO  
When did this first occur? \_\_\_\_\_ How often? \_\_\_\_\_
- 9) Have any dental appliances been prescribed?  YES  NO  
If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_  
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 mark each factor that applies to you)**

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

**HABIT HISTORY: (Please mark 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: (Please mark each symptom that applies)**

**A. 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

**B. EYE PAIN OR EAR ORBITAL PROBLEMS**

- Eye Pain – Above, Below or Behind  
 Bloodshot Eyes  
 Blurring of Vision  
 Bulging Appearance  
 Pressure Behind the Eyes  
 Light Sensitivity  
 Watering of the Eyes  
 Drooping of the Eyelids

**C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS**

- Discomfort  
 Limited Opening  
 Inability to Open Smoothly

**D. TEETH AND GUM PROBLEMS**

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

**E. JAW AND JAW JOINT (TMD) PROBLEMS**

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

**F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES**

- Hissing, Buzzing, Ringing or Roaring Sounds  
 Ear Pain without Infection  
 Clogged, Stuffy, Itchy Ears  
 Balance Problems – “Vertigo”  
 Diminished Hearing

**G. OTHER PAIN**

- If so, please describe: \_\_\_\_\_

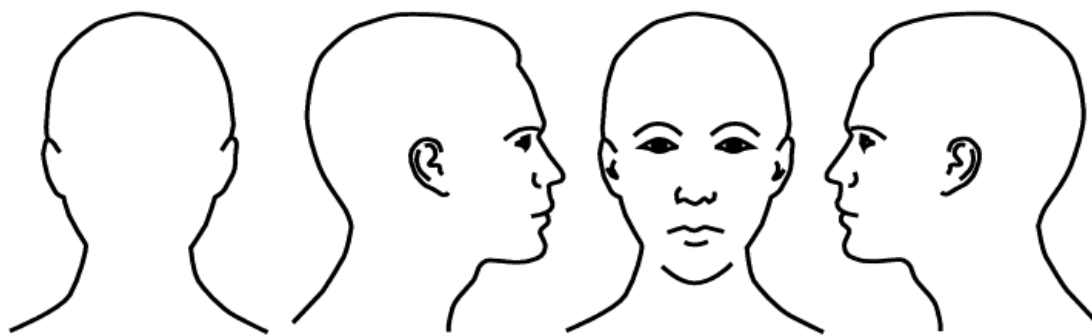
**H. THROAT PROBLEMS**

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

**I. 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

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



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