

Name: _____
 Date: _____

TMJ Patient History Form

Please answer all questions in detail.

1. Do you have any problems with your jaw? ___Yes ___No. If yes, please describe in detail.

How long have you had these problems? _____

2. Have you received treatment for these problems? ___Yes ___No.

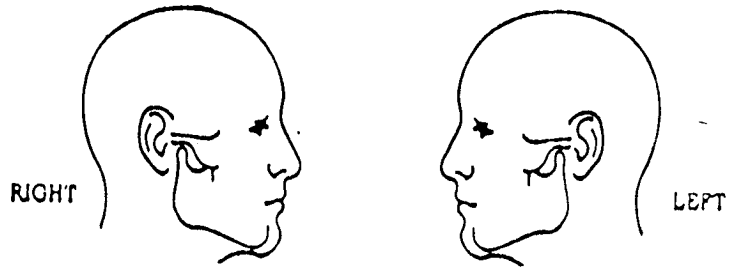
Who directed this treatment? _____

3. What was the treatment? (Please indicate)

			Results		
	Upper	Hard	Good	Fair	Poor
Bite splint	Lower	Soft	_____	_____	_____
Medication	_____	_____	_____	_____	_____
Physical therapy	_____	_____	_____	_____	_____
Occlusal adjustment	_____	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____	_____
Counseling	_____	_____	_____	_____	_____
Surgery	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

4. On the figures to the right, place a *circle* where you have pain and place a small *dot* where the pain is most severe.

5. Do you have frequent ...
 ...headaches? _____
 ...neck aches? _____
 ...shoulder aches? _____



When do you have this pain (morning, night, during eating, etc.)? _____

6. Do you do anything now to relieve your pain, i.e., heat, soft diet, Advil? ___Yes ___No If yes, what? _____

7. Are you aware of anything that makes your pain worse, i.e., chewing hard food, yawning? ___Yes ___No If yes, what? _____

8. Do your jaw joints make noise? ___Yes ___No. If yes, how long has this been occurring? _____

Right: Clicking _____ Popping _____ Grinding _____

Left: Clicking _____ Popping _____ Grinding _____

9. Has your jaw ever locked open (where you cannot close your mouth)? ___Yes ___No

If yes, for how long? _____ When did this first occur? _____

How often has this occurred? _____

10. Has your jaw ever locked closed or partially closed (where you cannot open your mouth)?

___Yes ___No If yes, for how long? _____ When did this first occur? _____

How often has this occurred? _____

11. Have you ever injured your jaws/face/neck? ___Yes ___No Had whiplash? ___Yes ___No

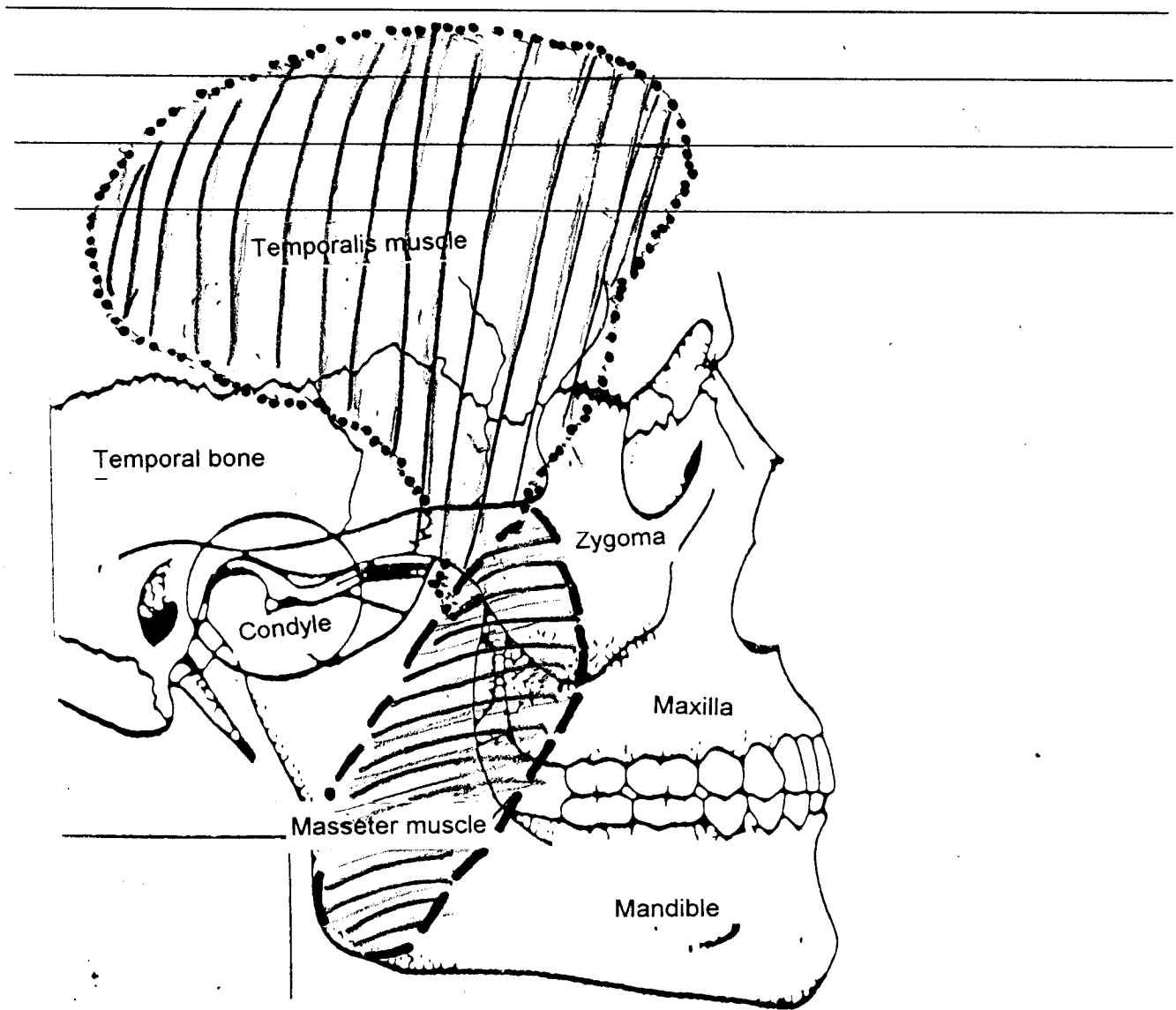
12. If yes, when? _____ Please describe the injury _____

13. Do you feel you are under more stress than more people? _____

If yes, why? _____

15. Do you clench or grind your teeth at night? _____

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



Normal jaw function

1. Incisal opening, 50mm
2. Open without pain
3. Open without noise
4. Open without deviation

Temp
 Mass.
 Lat. ptery.
 Med. ptery.

Occlusal Class I
 Class II
 Class III
 Crossbite
 Missing

Rx Flexeril
 Vioxx
 Motrin