American Association of Orthodontists

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? _____

_____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems

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

Teeth Problems

				Comments
Teeth grinding	☐ Yes	☐ No	When? _____	_____
Teeth clenching	☐ Yes	☐ No	When? _____	_____
Soreness of one or more teeth	☐ Yes	☐ No	Where? _____	_____
Looseness of one or more teeth	☐ Yes	☐ No	Where? _____	_____

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

Ear or Balance Problems

			Comments
Pain in ear	☐ Yes	☐ No	_____
Ringing or buzzing in ears	☐ Yes	☐ No	_____
Clogged or stuffy ears	☐ Yes	☐ No	_____
Diminished hearing	☐ Yes	☐ No	_____
Dizziness or vertigo	☐ Yes	☐ No	_____
Poor sense of balance	☐ Yes	☐ No	_____

SYMPTOMS *continued* Please mark each symptom that applies.

Throat Problems

			Comments
Swallowing difficulty	☐ Yes	☐ No	
Throat tightness	☐ Yes	☐ No	
Throat soreness	☐ Yes	☐ No	
Laryngitis	☐ Yes	☐ No	
Voice fluctuations	☐ Yes	☐ No	
Throat congestion	☐ Yes	☐ No	
Frequent cough	☐ Yes	☐ No	
Frequent throat clearing	☐ Yes	☐ No	
Excessive salivation	☐ Yes	☐ No	
Tongue pain	☐ Yes	☐ No	
Pain in roof of mouth	☐ Yes	☐ No	

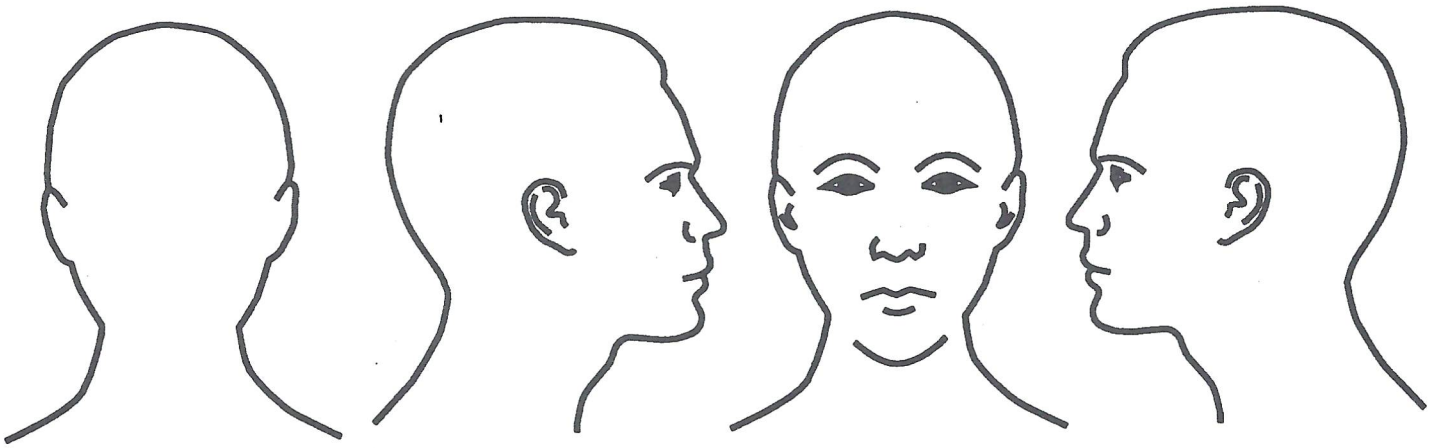
Neck and/or Shoulder Pain

			Comments
Neck/shoulder/back pain	☐ Yes	☐ No	
Neck/shoulder/back reduced mobility	☐ Yes	☐ No	
Frequent neck muscle fatigue	☐ Yes	☐ No	
Arm or finger tingling, numbness, pain	☐ Yes	☐ No	

Eye Problems

			Comments
Pain around or behind eyes	☐ Yes	☐ No	
Bloodshot eyes	☐ Yes	☐ No	
Blurred vision	☐ Yes	☐ No	
Pressure behind eyes	☐ Yes	☐ No	
Light sensitivity	☐ Yes	☐ No	
Watering of eyes	☐ Yes	☐ No	
Drooping of eyelids	☐ Yes	☐ No	

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



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? _____

_____

_____

UPDATES

Updates _____

_____

_____

_____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Updates _____

_____

_____

_____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Updates _____

_____

_____

_____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____

Updates _____

_____

_____

_____

Patient Signature _____ Date _____

Dental Staff Signature _____ Date _____