American Association of Orthodontists

HISTORY FORM FOR PATIENT WITH TEMPOROMANDIBULAR DISORDER

Date _____ Date of Birth _____
Name Dr. Mr. Mrs. Ms. Miss _____
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 _____

	Poor			Average						Excellent
2) How would you describe your overall physical health?	0	1	2	3	4	5	6	7	8	9	10
3) How would you describe your dental health?	0	1	2	3	4	5	6	7	8	9	10

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 circle 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?
Describe: _____
2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)
Describe: _____
3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)
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 circle below)
Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics Counseling Surgery
Other (Please explain) _____

CURRENT MEDICATIONS/APPLIANCES:

	No Pain				Moderate Pain					Severe Pain	
1) Degree of current TMD pain:	0	1	2	3	4	5	6	7	8	9	10

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? 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? _____

(CONTINUED ON REVERSE SIDE)

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 check each factor that applies to you)

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

HABIT HISTORY: (Circle 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: (Circle 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.