



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 \_\_\_\_\_
- 2) How would you describe your overall physical health? 

	<b>Poor</b>	<b>Average</b>	<b>Excellent</b>
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
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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 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:

- 1) Degree of current TMD pain: 

	<b>No Pain</b>	<b>Moderate Pain</b>	<b>Severe Pain</b>
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? \_\_\_\_\_

- 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)**

- |   |  |  |
|---|--|--|
| <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     |  |  |

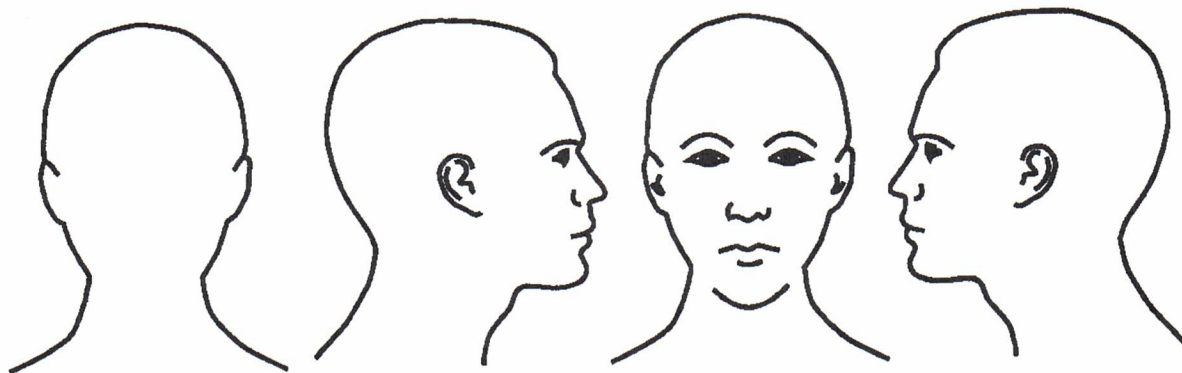
**HABIT HISTORY: (Circle your answer to each question)**

- 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)**

- |  |   |  |
|--|---|--|
| <p>A. HEAD PAIN, HEADACHES, FACIAL PAIN</p> <p>Forehead L R<br/>         Temples L R<br/>         Migraine Type Headaches<br/>         Cluster Headaches<br/>         Maxillary Sinus Headaches (under the eyes)<br/>         Occipital Headaches (back of the head with or without shooting pain)<br/>         Hair and/or Scalp Painful to Touch</p> | <p>D. TEETH AND GUM PROBLEMS</p> <p>Clenching, Grinding at Night<br/>         Looseness and/or Soreness of Back Teeth<br/>         Tooth Pain</p>   | <p>H. THROAT PROBLEMS</p> <p>Swallowing Difficulties<br/>         Tightness of Throat<br/>         Sore Throat<br/>         Voice Fluctuations<br/>         Laryngitis<br/>         Frequent Coughing/Clearing Throat<br/>         Feeling of Foreign Object in Throat<br/>         Tongue Pain<br/>         Salivation<br/>         Pain in the Hard Palate</p> |
| <p>B. EYE PAIN OR EAR ORBITAL PROBLEMS</p> <p>Eye Pain - Above, Below or Behind<br/>         Bloodshot Eyes<br/>         Blurring of Vision<br/>         Bulging Appearance<br/>         Pressure Behind the Eyes<br/>         Light Sensitivity<br/>         Watering of the Eyes<br/>         Drooping of the Eyelids</p>                            | <p>E. JAW AND JAW JOINT (TMD) PROBLEMS</p> <p>Clicking, Popping Jaw Joints<br/>         Grating Sounds<br/>         Jaw Locking Opened or Closed<br/>         Pain in Check Muscles<br/>         Uncontrollable Jaw/Tongue Movements</p>                        | <p>I. NECK AND SHOULDER PAIN</p> <p>Reduced Mobility and Range of Motion<br/>         Stiffness<br/>         Neck Pain<br/>         Tired, Sore Neck Muscles<br/>         Back Pain, Upper and Lower Shoulder Aches<br/>         Arm and Finger Tingling, Numbness, Pain</p>   |
| <p>C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS</p> <p>Discomfort<br/>         Limited Opening<br/>         Inability to Open Smoothly</p>  | <p>F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES</p> <p>Hissing, Buzzing, Ringing or Roaring Sounds<br/>         Ear Pain without Infection<br/>         Clogged, Stuffy, Itchy Ears<br/>         Balance Problems - "Vertigo"<br/>         Diminished Hearing</p> |  |
|  | <p>G. OTHER PAIN</p> <p>If so, please describe:<br/>         _____</p>  |  |

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



## Notice of Privacy Practices Acknowledgement

Rodney D. Hyduk, DDS, MSD, PC  
90 W. Square Lake Rd.  
Troy, MI 48098

42450 Garfield  
Clinton Twp. MI 48038

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Bill third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that a copy of your Notice of Privacy is available for review upon request, containing a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Signature of Patient (Parent if Minor): \_\_\_\_\_

Relationship to Patient (if parent): \_\_\_\_\_

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

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### Office use only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason
_____	_____	_____
_____	_____	_____

