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: ______________________

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

HABIT HISTORY: (Check 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: (Check 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

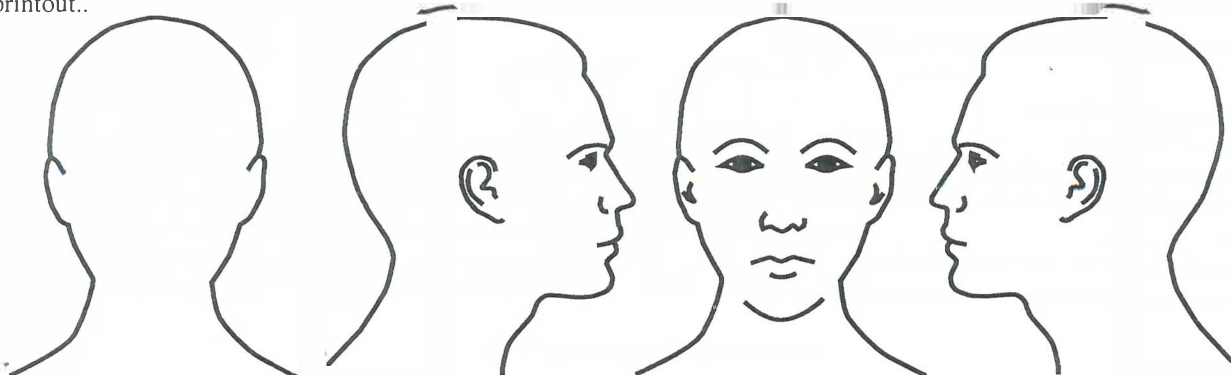
F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES
Hissing, Buzzing, Ringing or Roaring Sounds
Ear Pain without Infection
Clogged, Stuffy, Itchy Ears
Balance Problems — "Vertigo"
Diminished Hearing

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. Please complete in office with printout..



Temporomandibular Joint Questionnaire

Patient's Name:______________________ Age: ______ Sex: ______ Date:____________

If you can answer YES to the question, select the box under YES. If you have to answer NO to the question, select the box under NO. Please answer all questions.

	YES	NO
1. Do you have clicking, popping, or grating noise in your		
Right jaw joint?	☐	☐
Left jaw joint?	☐	☐
2. When did you first notice the noise?______________________		
3. Has the noise recently become more pronounced?	☐	☐
When?______________________		
4. Do you have pain in or around the right joint?	☐	☐
Left joint?	☐	☐
5. When did you first notice the pain?______________________		
6. Has the pain become more pronounced recently?	☐	☐
When?______________________		

7. Is the pain worse: Mornings ☐ At meal times ☐ Evenings ☐ No specific time ☐

8. Is this pain: Dull ☐ Continuous ☐ Stabbing ☐ Intermittent ☐ Throbbing ☐ Other ☐

9. Does the pain sometime feel like it is in your ear?	☐	☐
10. Do you think this problem has affected your hearing?	☐	☐
11. Does your jaw problem interfere with your normal activities?	☐	☐
12. Are you taking or have you taken medication for this problem?	☐	☐
Explain ______________________		
13. Did anything occur that might be related to the onset of this problem?	☐	☐
Explain ______________________		
14. Do you have difficulty chewing?	☐	☐

Because of: Pain in joint ☐ Limited opening ☐ Pain in teeth ☐ Missing teeth ☐ Clicking ☐ Other ☐

15. Has your mouth ever locked open so you were unable to close it?	☐	☐
Explain ______________________		

	YES	NO
16. Have you had problems with opening your mouth wide?	☐	☐

Explain ______________________________

____

17. Please indicate the time sequence in which you became aware of the following problems (1st, 2nd, etc.) Number only those that apply to you

Pain __________ Noise __________ Locking __________ Other __________

18. Which aspects of your problems concerns you the most?

____

____

	YES	NO
19. Are you aware of clenching your teeth?	☐	☐
20. Do you grind your teeth?	☐	☐

When? ______________________________

	YES	NO
21. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in immediate family, or other stressful events?	☐	☐
22. Do you think nervous tension seems to affect this problem?	☐	☐

Explain ______________________________

____

	YES	NO
23. Have you had problems with other joints?	☐	☐
24. Have you had orthodontic treatment?	☐	☐

When ______________________________

	YES	NO
25. Have you had recent dental treatment?	☐	☐

When ______________________________

	YES	NO
26. Have you had x-rays taken for this problem?	☐	☐

When __________ Where ______________________________

	YES	NO
27. Have you recieved previous treatment for this problem?	☐	☐

Patient Consent Form

L. Douglas Knight, DMD, ABO

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.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

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 that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:______________________________ Date: ____________
(Please Print)

Parent/Guardian Signature: ______________________________________