

TMJ History

Today's Date _____ Sex: M F
Name _____ Birthdate _____
Address _____ Zip Code _____
Phone Number _____ Occupation _____

Describe your dental problems, if any: _____

Pain

A) Does your face or jaw hurt anywhere? Yes No (if no, skip to "F" and then 5)

B) How long has it hurt? _____

C) Please grade the severity of your pain on a scale from 1-5.

1 is barely noticeable to 5 being worst pain you can imagine

Right Side	0	1	2	3	4	5	
Left Side		0	1	2	3	4	5

D) Is the pain worse in the: Morning Afternoon Evening

Is the pain: Constant Intermittent

If intermittent, what percentage of waking hours does your jaw hurt? _____ %

1. Has your jaw ever locked? yes no

2. Do you have:

	Right Side	Left Side
Ringing in ears?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Dizziness?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>
Change in hearing?	yes <input type="checkbox"/> no <input type="checkbox"/>	yes <input type="checkbox"/> no <input type="checkbox"/>

3. Do you grind your teeth? yes no

 If yes, when? Night Day Both

 Do you grind your teeth? yes no

 If yes, when? Night Day Both

4. Sore or sensitive teeth? yes no

5. Trouble sleeping? yes no

6. Do you consider yourself to be under a lot of stress? yes no

7. Are you nervous or anxious about anything? yes no

8. Have you ever had nervous stomach, ulcers, or skin disease? yes no

9. Do you have or have you ever had arthritis? yes no

10. Can you remember sustaining any injury to your face or jaw? yes no

11. Have you ever had a whiplash injury? yes no

12. Have you had any operation or procedure in the last few years during which you were required to hold your mouth widely open for a long period of time? yes no

 If yes, what was the procedure? _____

13. Do you take medications for the pain or relaxation? yes no

 If yes, what? _____

14. Have you had any treatments for your problems? yes no

 If yes, what kind?

 A) Bite Splint

 B) Medication

 C) Physical Therapy

 D) Other-describe _____