Green Hills
DENTAL GROUP
John L. Farringer III, D.D.S.

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 □ Intemittent □
If intermittent, what percentage of waking hours does your jaw hurt? ________ %

E) On the figures below, please outline where your pain is, and place and "X" on the most painful site:

Right Side Left Side

F) Do you have:

	Right Side	Left Side
headaches:	yes □ no □	yes □ no □
neckaches:	yes □ no □	yes □ no □
shoulder pain:	yes □ no □	yes □ no □
ear pain	yes □ no □	yes □ no □

G) Does moving your jaw make the pain worse? yes □ no □

H) Does chewing with your jaw make the pain worse? yes □ no □

I)What measures do you find helpful relieving the pain ______________________
____

J) Does your pain keep you from doing anything? yes □ no

If yes, what?____

Noise

A) Does your jaw make noise: Right Side yes □ no □ Left Side yes □ no □

B) If your jaw makes noise, describe the noise it makes on the:

Right side: ___________________ Left Side_______________________

C) What jaw movements cause the noise to occur _______________________
____

D) How long has the noise been present? ____________________

E) Is the noise associated with the pain? yes □ no □

F) If your jaw does not make noise, did it ever make noise in the past? yes □ no □

1. Has your jaw ever locked? yes □ no □
2. Do you have:

	Right Side	Left Side
Ringing in ears?	yes □ no □	yes □ no □
Dizziness?	yes □ no □	yes □ no □
Change in hearing?	yes □ no □	yes □ no □

3. Do you grind your teeth? yes □ no □
   If yes, when? Night □ Day □ Both □
   Do you clench your teeth? yes □ no □
   If yes, when? Night □ Day □ Both □
4. Sore or senstive 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 skind 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______________________________________