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# TEMPOROMANDIBULAR DISORDER HISTORY

Today's Date _____

Patient Name _____ Date of Birth _____ Age _____

**1.** ***Please explain your problem or concern***: _____

_____

_____

_____

**2.** ***PERTINENT MEDICAL HISTORY***

- Date of last physical exam: _____
- Physician's Name: _____Office Phone: _____
- Please list all previous hospitalizations below:

| | *Year* | *#Days in Hospital* | *Condition Being Treated* |
|---|---|---|---|
| Most recent Hospitalization | _____ | _____ | _____ |
| 2nd Most recent Hospitalization | _____ | _____ | _____ |
| 3rd Most recent Hospitalization | _____ | _____ | _____ |

- Have you ever been diagnosed as having arthritis? (circle) YES NO
  If yes, please check all below that apply:

  ____ Osteoarthritis
  ____ Rheumatoid Arthritis
  ____ Gout
  ____ Systemic Lupus Erythematous
  ____ Sjogren's Disease
  ____ Scleroderma
  ____ Fibromyalgia
  ____ Other _____

- Has there been a change in your health during the last year? YES NO
  If yes, please explain: _____

  _____

  _____

- Compared with other people about your age, do you feel your health is:

  Excellent Good Fair Poor

- Do you have numbness or tingling in any part of your body? YES NO

  If yes, please describe location and frequency: _____

  _____

F = Frequent S= Seldom N= Never

- ***During the past 3 years have you experienced:***

| | | | |
|---|---|---|---|
| 1. Sores in your mouth, or on lips that are slow to heal? | F | S | N |
| 2. Dry mouth? | F | S | N |
| 3. Difficulty swallowing? | F | S | N |
| 4. Sinus problems? | F | S | N |
| 5. Dizziness/loss of equilibrium? | F | S | N |
| 6. Plugging or fullness of the ears? | F | S | N |
| 7. Ringing or buzzing sounds? | F | S | N |
| 8. Earaches? | F | S | N |
| 9. Temporary hearing loss? | F | S | N |

- Have you sought treatment for ear problems during the last 3 years? YES NO
- When did you last have your vision checked? Date: _____
- ***Do you have insomnia or other sleep disturbances such as:***

| | | | |
|---|---|---|---|
| 1. Difficulty falling asleep? | F | S | N |
| 2. Early morning awakening? | F | S | N |
| 3. Restless sleep (frequent arousal)? | F | S | N |

### *3. HEADACHE/FACIAL PAIN (as distinguished separately from jaw joint pain)*

Indicate all the areas where you now have headaches/facial pain by circling the appropriate location and frequency:

| ***HEAD*** | | | | ***FACE*** | | | |
|---|---|---|---|---|---|---|---|
| Forehead | F | S | N | Cheeks | F | S | N |
| Top if head | F | S | N | In area of ear & TMJ | F | S | N |
| Side of head | F | S | N | Below ear & TMJ | F | S | N |
| Back of head | F | S | N | In front of ear & TMJ | F | S | N |
| Sinuses | F | S | N | Inside of ear & TMJ | F | S | N |
| ***BELOW HEAD*** | | | | ***EYES*** | | | |
| Back of neck | F | S | N | Pain in eyes | F | S | N |
| Side of neck | F | S | N | Sensitivity of light | F | S | N |
| Neck noises | F | S | N | Pressure in eyes | F | S | N |
| Shoulders | F | S | N | | | | |

- Do your headaches/facial pain interfere with your work, recreation, social activities, or there daily activities? F S N

- Overall, would you rate your headaches/facial pain as: ***mild*** ***moderate*** ***severe***
- Has the ***severity*** of your headache/facial pain:
  **_____ recently increased**
  **_____ remained the same**
  **_____ recently decreased**
- Has the ***frequency*** of your headaches/facial pain:
  **_____ recently increased**
  **_____ remained the same**
  **_____ recently decreased**
- How long does your headaches/facial pain last?
  **_____ Minutes**
  **_____ Hours**
  **_____ More than a day**
- How long have your headaches/facial pain been a problem for you?
  **_____ Days**
  **_____ Weeks**
  **_____ Months**
  **_____ A year or more**
- How often do you wake up in the morning with headaches/facial pain?
  **_____ Daily**
  **_____ Weekly**
  **_____ Occasionally**
- Do headaches/facial pain ever awaken you from your sleep?
  **_____ Nightly**
  **_____ Weekly**
  **_____ Rarely**
- Do you have visual disturbances with your headaches? F S N
- Do you have nausea with your headaches? F S N
- Has a physician said that you have migraine headaches? YES NO
- Does bending over aggravate your headaches/facial pain? F S N
- Do you have to go to bed to control your headaches or facial pain? F S N
- Does freeway driving cause headaches/facial pain? F S N
- Do you have fewer headaches/facial pain on weekends? YES NO
- How much relief do you gain from taking aspirin, ibuprophen, or Tylenol? ***No relief*** ***Partial relief*** ***Complete relief*** ***don't know***

## *4. JAW JOINT PROBLEMS*

- Do you have difficulty chewing? YES NO
  If yes, is it because of:
  **_____ Missing teeth**
  **_____ Pain in teeth**
  **_____ Clicking/popping jaw joints**
  **_____ Locking/catching jaw joints**
  **_____ Limited ability to open mouth**

- Does gum chewing cause discomfort and/or joint noise? YES NO I don't chew gum
- Do you have a favorite side for chewing?
  _____ **Right Side**
  _____ **Left Side**
  _____ **Do not know**
  _____ **No**
- Do you have pain specifically in your jaw joints?
  **Right Side: F S N**
  **Left Side: F S N**
- Can you recall a specific time when the discomfort first occurred? YES NO
  If yes, please describe: _____
  _____
- Is your general level of jaw joint discomfort worse:
  _____ **On waking**
  _____ **End of day**
  _____ **With meals**
  _____ **Variable**
- Within the past six months, has your overall level of jaw discomfort:
  _____ **Increased**
  _____ **Stayed the same**
  _____ **Decreased**
- How many nights during the past week have you been awakened by pain or discomfort in your jaw joints? _____times
- Does physical exertion aggravate your jaw joint pain? F S N
- Does cold, damp weather aggravate the problem? F S N
- Have you ever noticed swelling or puffiness over your jaw joints? F S N
- Have you been aware of sounds in your jaw joints? **Right Side:** YES NO
  **Left Side:** YES NO
- Please check the appropriate answers which pertain to your jaw sounds:

| (Circle) | RIGHT | LEFT | NEITHER |
|---|---|---|---|
| Clicking, popping, snapping | _____ | _____ | _____ |
| Grinding, gravely, gristly | _____ | _____ | _____ |
| Previous noise has stopped | _____ | _____ | _____ |

- How long have you been aware of your jaw joint sounds? _____
- If sounds occur on both sides, which started first? **right side left side don't know**
- Do you recall the specific time when you first noticed joint sounds: YES NO
  If yes, please describe: _____
  _____
- Has the character or frequency of your jaw joint noise changed? YES NO
  If yes, please describe: _____
  _____
- Does the noise occur when you are:
  **Eating** F S N
  **Talking** F S N
  **Yawning** F S N
  **Swallowing** F S N

- Is the noise audible to others in the room? F S N
- Is there any ***pain associated with the noise*** in your jaw joints? F S N

## 5. JAW MOVEMENT

- Do you have limited ability to open your mouth? YES NO

  If yes, was the onset gradual or sudden? _____
- Has your jaw ever locked in a ***closed*** position so that you were not able to open as wide has usual? YES NO

  If yes, how many times has this happened?
  **_____ Once**
  **_____ a few times**
  **_____ several times/often**

- Has your jaw ever locked in an ***open*** position so that you were not able to close your teeth all the way together? YES NO

  If yes, how many times has this happened?
  **_____ Once**
  **_____ a few times**
  **_____ several times/often**
- Locking usually occurs:
  **_____ has never occurred**
  **_____ on awakening**
  **_____ during eating**
  **_____ when yawning**
  **_____ during long dental appointments**
- Have you ever had to have someone manipulate your jaw to get it unlocked? YES NO
- TMJ symptoms often occur in a specific sequence. It is helpful for us to know this sequence. Please place a "1" next to the symptom that occurred first. Place a "2" after the symptom that occurred next, and so forth. Place an "x" next to any symptoms you have not experienced.

**_____ Headaches** **_____ Face or joint pain other than headaches**
**_____ Limited jaw opening** **_____ Clicking, popping, or snapping sound in joint**
**_____ Locking or catching of the jaw** **_____ Grinding, grating, or gravely sound in joint**
**_____ other; please explain** _____

_____

## 6. DENTAL HISTORY

- Are you having any dental problems at this time? _____ _____

  _____
- Do you have any pain in your teeth when you chew or bite? _____ _____

  _____
- Do you have any teeth that are sensitive to sweets or colds? _____ _____

  _____

- When was your last visit to a general dentist? _____
- Are you missing any teeth? _____
- Have you had very much dental treatment in the past? If yes, explain: _____ _____

  _____ _____

  _____

- Is it difficult to find a comfortable bite position? YES NO
- Have you noticed any recent changes in your bite? YES NO
- Have you ever had orthodontic treatment (braces)? YES NO
- Have you ever had your bite adjusted by a dentist?
  (a dentist changed your bite by grinding on your teeth) YES NO

  If yes, how many times has this been done to your teeth? _____
- Are you aware – or – have others told you that you:

**Grind your teeth**
_____ I do not think I grind my teeth
_____ I grind while sleeping
_____ I grind while awake

_____ I am not sure if I grind my teeth

**Clench your teeth**
_____ I do not think I clench my teeth
_____ I clench while sleeping
_____ I clench while awake

_____ I am not sure if I clench my teeth

**7. SLEEP DISORDER** (circle)

- I feel sleepy during the day, even when I get a good night's sleep. True False
- I am often irritable because I can't sleep. True False
- I often have trouble concentrating because I can't sleep True False
- I often wake up at night and have trouble falling back to sleep. True False
- It usually takes me a long time to fall asleep. True False
- I often wake up very early and then can't fall back to sleep. True False
- I sometimes wake up and find myself gasping for breath. True False
- I regularly need to get up in the night to use the bathroom. True False

**8. LIFESYLE**

- How often do you exercise or participate in an active physical sport such as jogging, swimming, cycling, etc? _____**daily** _____**weekly** _____**monthly** _____**rarely**

- Do you consider yourself more tense than calm or more calm than tense?
  _____ **very calm** _____ **somewhat calm** _____ **average** _____ **somewhat tense** _____ **very tense**

- How often do you feel depressed?
  _____ **never** _____ **rarely** _____ **sometimes** _____**often** _____ **always**

- What affect do you think nervous tension has on your jaw problems, headaches, or facial pain? ___

  _____ _____

  _____

- Has there been recent change in your lifestyle such as change in martial status, recent illness, family problems, death in your immediate family, excessive work-related stress or other stressful events? **YES NO**

  If yes, please explain: _____ _____

  _____ _____

  _____

- Do you think that any of the following may cause or aggravate your headaches, facial pain, or jaw joint problems?

| | | | |
|---|---|---|---|
| **Visual strain** | **F** | **S** | **N** |
| **Sinus problems** | **F** | **S** | **N** |
| **Food allergies** | **F** | **S** | **N** |
| **Stress** | **F** | **S** | **N** |

- What conditions or activities make your joint pain or headache/facial pain most noticeable: _____

  _____ _____

  _____

- What aspect of your joint problem or headache/facial pain concerns you the most? _____

  _____

- Do your daily activities include:

| | | | |
|---|---|---|---|
| **- Prolonged uncomfortable positioning of the head, neck or shoulders?** | **F** | **S** | **N** |
| **- Prolonged leaning over a desk or working with your arms forward?** | **F** | **S** | **N** |
| **- Prolonged turning of the head forward or to one side such as while telephoning?** | **F** | **S** | **N** |
| **- Frequently lifting or moving heavy objects?** | **F** | **S** | **N** |
| **- Frequently carrying something heavy such as a baby or briefcase on one side?** | **F** | **S** | **N** |
| **- Prolonged periods of intense concentration?** | **F** | **S** | **N** |
| **- Frequent placement of objects in your mouth (i.e. musical instrument, etc)** | **F** | **S** | **N** |
| **- Frequent gum chewing?** | **F** | **S** | **N** |

## 9. HISTORY OF INJURY OR TRAUMA TO HEAD AND NECK AREA

- Have you ever received a blow or trauma to your chin or face that may relate to the onset of your jaw joint problem? YES NO

  If yes, please describe: _____

  _____

- Have you ever experienced a whiplash injury? YES NO

  If yes, please describe the time and problem: _____

  _____

- Have you ever worn a cervical collar, neck brace, or back brace? YES NO

  If yes, please describe the time and problem: _____

  _____

- Have you ever had cervical traction or a neck injury? YES NO

  If yes, please describe the circumstances: _____

  _____

- Are you involved with or contemplating legal action related to your jaw problem, headache/facial pain, or whiplash injury? YES NO

**10.HISTORY OF PREVIOUS TREATMENT**

- What do you typically do to help relieve your jaw joint or headache/facial joint? _____
  _____
  _____
- Have you ever had any of the following?
  - **Individual or group counseling for stress-related problems** YES NO Year _____
  - **Psychiatric Care** YES NO Year _____
  - **Depression** YES NO Year _____
- Have you ever worn a bite guard, bite splint or other dental appliance to treat your jaw problem, headaches, pain, or grinding? YES NO
  If yes, was the appliance: _____ **hard**
  _____ **soft, rubbery**

  Did you: _____ **wear it at night only**
  _____ **wear it all the time**

  Did wearing the appliance seem to help? _____
- Have you ever had x-rays taken of your jaw joints? YES NO
  If yes, when (date) and by whom were they taken? _____ _____
  _____
- Has your jaw joint/facial pain/headaches been treated by:

| ***Treatment type*** | ***By*** | ***When*** | ***Outcome of treatment*** |
|---|---|---|---|
| Biofeedback | | | |
| Counseling | | | |
| Hypnosis | | | |
| Soft diet | | | |
| Injections into muscles | | | |

| | | | |
|---|---|---|---|
| Injections into jaw joints | | | |
| Jaw joint surgery | | | |
| Physical therapy | | | |
| Jaw exercises | | | |
| Moist heat | | | |
| Massage | | | |
| Acupuncture | | | |
| Chiropractic/Osteopathic | | | |
| Sleep Study/Evaluation | | | |
| Other (explain) | | | |

**I verify that the information I have provided on this Temporomandibular Disorder History is true, complete, and accurate to the best of my knowledge.**

**Patient Signature** **Date** **Reviewed by** **Date**

The information above is not intended to be a substitute for personalized dental advice, diagnosis, or treatment. Always seek the advice of your dentist with any questions you may have regarding a dental condition.