



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?

Poor	Average	Excellent
0	1 2 3 4 5 6 7 8 9	10
- 3) How would you describe your dental health?

Poor	Average	Excellent
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:

- 1) Degree of current TMD pain:

No Pain	Moderate Pain	Severe 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)

- | | | |
|---|--|--|
| <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)

- | | | |
|---|--|---|
| 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 | D. TEETH AND GUM PROBLEMS
Clenching, Grinding at Night
Looseness and/or Soreness of Back Teeth
Tooth Pain | 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 |
| 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 | 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 | 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 |
| C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS
Discomfort
Limited Opening
Inability to Open Smoothly | 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: _____ | |

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

