TMD Health History Form

Center for Cosmetic, Implant & Neuromuscular Dentistry

SID SOLOMON, DDS

CENTER FOR COSMETIC, IMPLANT AND NEUROMUSCULAR DENTISTRY

General Dentistry, Cranio-Mandibular Facial Pain & Esthetic Orthopedic Rehabilitation

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Patient's Name: ____________________________ Email:_________________________________
Patient's Cell Phone:________________________ Home Phone:___________________________
Date of Birth: ______________________________ Age: _______ Sex: Male☐ Female ☐
S.S.N. /S.I.N.: ______________________________
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: ____

	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 mark procedure(s): ☐Orthodontics ☐Periodontics ☐Oral Surgery ☐Restorative
Date(s) of Third Molar (wisdom tooth) extraction(s): ____________

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FACIAL INJURY/TRAUMA HISTORY:

1) Is there any childhood history of falls, accidents or injury to the face or head? ☐YES ☐NO
Describe: ____

2) Is there any recent history of trauma to the head or face? ☐YES ☐NO
Describe: ____

3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming) ☐YES ☐NO
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 mark below)
☐Bite ☐Splint ☐Medication ☐Physical Therapy ☐Occlusal Adjustment ☐Orthodontics ☐Counseling ☐Surgery
Other (Please explain)____

7) Have you ever had injections for your TMD with muscle relaxants (BOTOX®, Flexoril) cortisone or anti- inflammatories? __________ Were they effective: ☐Yes ☐NO

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

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? _____________________

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? _______________________________________

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CURRENT STRESS FACTORS: (Please select all applicable)

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

HABIT HISTORY: (Please mark 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

SYMPTOMS: (Please mark 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
☐Jaw Locking Opened or Closed

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
☐Balance Problems – "Vertigo"

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
☐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
☐Pain
☐Diminished Hearing
☐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

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,

G. OTHER PAIN

☐If so, please describe: ________________________________