EAST TENNESSEE ORTHODONTICS

1143 Oak Ridge Turnpike Suite 206
865-312-6264

Temporomandibular Disorder History Form

Date _____

Name _____ Birth date _____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems	Left	Right	
Joint clicking or popping	☐Yes ☐No	☐Yes ☐No	Comments _____
Grating noises	☐Yes ☐No	☐Yes ☐No	Comments _____
Jaw locks open	☐Yes ☐No	☐Yes ☐No	Comments _____
Jaw locks closed	☐Yes ☐No	☐Yes ☐No	Comments _____
Limited jaw opening	☐Yes ☐No	☐Yes ☐No	Comments _____
Jaw does not open smoothly	☐Yes ☐No	☐Yes ☐No	Comments _____
Soreness of jaw joints	☐Yes ☐No	☐Yes ☐No	Comments _____
Soreness of face muscles	☐Yes ☐No	☐Yes ☐No	Comments _____

Teeth Problems			
Teeth grinding	☐Yes ☐No	☐Yes ☐No	Comments _____
Teeth clenching	☐Yes ☐No	☐Yes ☐No	Comments _____
Soreness of one or more teeth	☐Yes ☐No	☐Yes ☐No	Comments _____
Looseness of one or more teeth	☐Yes ☐No	☐Yes ☐No	Comments _____

Head and Facial Pain	Left	Right	(least) Degree of Pain (most)
Migraine type headache	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Cluster headaches	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Sinus headaches	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Headaches in back of head	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
Hair and/or scalp painful to touch	☐Yes ☐No	☐Yes ☐No	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Ear or Balance Problems		
Pain in ear	☐Yes ☐No	Comments _____
Ringing or buzzing	☐Yes ☐No	Comments _____
Clogged or stuffy ears	☐Yes ☐No	Comments _____
Diminished hearing	☐Yes ☐No	Comments _____
Dizziness or vertigo	☐Yes ☐No	Comments _____
Poor sense of balance	☐Yes ☐No	Comments _____

Throat Problems

Swallowing difficulty	☐Yes ☐No	Comments	_____
Throat tightness	☐Yes ☐No	Comments	_____
Throat soreness	☐Yes ☐No	Comments	_____
Laryngitis	☐Yes ☐No	Comments	_____
Voice fluctuations	☐Yes ☐No	Comments	_____
Throat congestion	☐Yes ☐No	Comments	_____
Frequent cough	☐Yes ☐No	Comments	_____
Frequent throat clearing	☐Yes ☐No	Comments	_____
Excessive salivation	☐Yes ☐No	Comments	_____
Tongue pain	☐Yes ☐No	Comments	_____
Pain in roof of mouth	☐Yes ☐No	Comments	_____

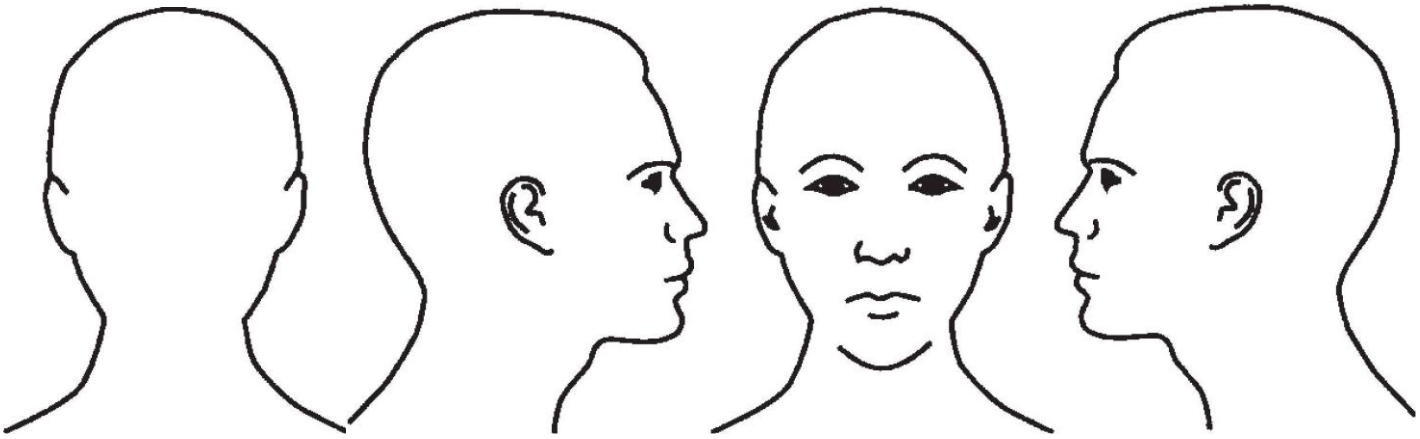
Neck and/or Shoulder Pain

Neck/shoulder/back pain	☐Yes ☐No	Comments	_____
Neck/shoulder/back reduced mobility	☐Yes ☐No	Comments	_____
Frequent neck muscle fatigue	☐Yes ☐No	Comments	_____
Arm or finger tingling, numbness, pain	☐Yes ☐No	Comments	_____

Eye Problems

Pain around or behind eyes	☐Yes ☐No	Comments	_____
Bloodshot eyes	☐Yes ☐No	Comments	_____
Blurred vision	☐Yes ☐No	Comments	_____
Pressure behind eyes	☐Yes ☐No	Comments	_____
Light sensitivity	☐Yes ☐No	Comments	_____
Watering of eyes	☐Yes ☐No	Comments	_____
Drooping of eyelids	☐Yes ☐No	Comments	_____

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



PATIENT HEALTH INFORMATION

Do you have any recent or childhood history of trauma to the head or face (such as falls, auto accident, blows to the head or face, sports injury)? If yes, please describe: _____

Do you have a frequent activity that causes you to hold your head or neck in an imbalanced position (such as playing instrument, keyboarding, holding phone, etc)? If yes, please describe: _____

Have you been treated for a TMD problem before? If so, when?_____ By whom? _____

Was the problem the same or different than your current problem? _____

What treatment did you have? _____

Do you think the treatment was successful? _____

What would you like your treatment here to achieve? _____

UPDATES

Updates _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Updates _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____

Updates _____

Patient Signature _____ Date_____

Dental Staff Signature _____ Date_____