American Association of Orthodontists®

History Form for Patient with Temporomandibular Disorder

Date _____ Estimated date problems started _____

Name _____ Birth date _____

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

_____

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 in ears	☐ 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_____

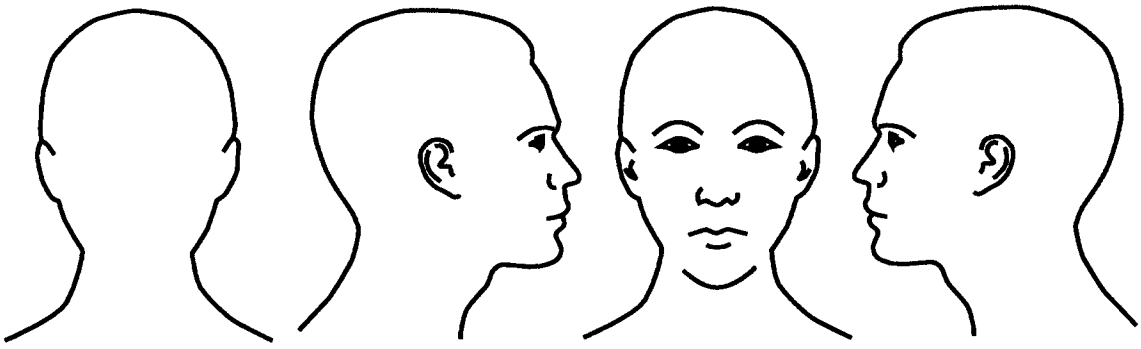
Neck and/or Shoulder Pain

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	☐ 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_____

At the office visit be prepared to show 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 _____