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TMJ Form

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Name: ______________________ Date: ____________

Birthdate: ____________ Occupation: ______________________

Referred by: ______________________ SS# ____________

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Please answer all questions to the best of your ability - use additional paper if necessary.

1. Describe your problem

2. Do you have a clicking, popping or grating noise in your
   - Right Jaw Joint ◯ Yes ◯ No
   - Left Jaw Joint ◯ Yes ◯ No

3. When did you first notice the noise?
   Right: ____________ Left: ____________

4. Has the noise recently become more pronounced? ◯ Yes ◯ No
   When? ______________________

5. Do you have pain in or around the right joint? ◯ Yes ◯ No
   Do you have pain in or around the left joint? ◯ Yes ◯ No

6. When did you first notice the pain?
   Right: ____________ Left: ____________

7. Is the pain worse:
   - ☐ Mornings: ☐ At Meals:
   - ☐ Evenings: ☐ No Specific Time:

8. Has the pain recently become more pronounced? ◯ Yes ◯ No
   When? ______________________

9. Is the pain:
   - ☐ Dull, achy ☐ Continuous ☐ Sharp, Stabbing
   - ☐ Intermittent ☐ Throbbing
   - ☐ If other, please describe: ______________________

10. Does the pain sometimes feel like it's in your ear? ◯ Yes ◯ No

11. Do you think this problem has affected your hearing? ◯ Yes ◯ No

12. Do you hear a ringing noise (tinnitus)? ◯ Yes ◯ No
    - ☐ Constant ☐ Intermittent

13. Do you have vertigo (periods of dizziness)? ◯ Yes ◯ No

14. Does your jaw problem interfere with your normal activities? ◯ Yes ◯ No

15. Do you have any idea what triggered the problem, what caused it, or what makes the problem continue? ◯ Yes ◯ No

Explain

16. Do you have frequent headaches or neckaches? ◯ Yes ◯ No

What Area(s)? ______________________

How Frequent? ______________________

17. Have you ever had a severe blow or trauma to the head, neck, or jaw? ◯ Yes ◯ No

Which area? ______________________

Explain: ______________________

18. Do you have difficulty chewing? ◯ Yes ◯ No

☐ Because of Pain in Joint ☐ Limited Opening ☐ Pain in Teeth

☐ Missing Teeth ☐ Clicking

☐ Other: ______________________

19. Has your mouth ever locked open so you were unable to close it? ◯ Yes ◯ No

Explain

20. Have you had problems opening your mouth wide? ◯ Yes ◯ No

Explain

21. Do you feel as if your teeth don't have a "home base" to close to, or that your bite is changing? ◯ Yes ◯ No

22. Have you ever been told that you grind your teeth during sleep? ◯ Yes ◯ No

23. Please indicate the time sequence in which you became aware of the following problems list. Number only those problems that apply to you. ◯ Yes ◯ No

Pain: __________ Noise: __________ Limited opening: __________

Locking: __________ Other: ______________________

24. Which aspects of your problem concern you the most?

Explain

25. Are you aware of clenching your teeth? ◯ Yes ◯ No

26. Do you grind your teeth? ◯ Yes ◯ No

27. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in the immediate family or other stressful events? ◯ Yes ◯ No

Explain

28. Do you have young children under your care? ◯ Yes ◯ No

29. Do you smoke a pipe? ◯ Yes ◯ No

Do you chew gum? ◯ Yes ◯ No

Do you bite your nails? ◯ Yes ◯ No

Do you have any other nervous habits? ◯ Yes ◯ No

30. Describe any habits at work or home which might place your body in a strained or awkward posture (such as holding a phone with a shoulder or carrying equipment.

____

31. Do you think nervous tension seems to affect this problem? ◯ Yes ◯ No

Explain

32. Have you had problems with other joints? ◯ Yes ◯ No

Explain

33. Is there any history of similar problems in your family? ◯ Yes ◯ No

34. Have you had orthodontic treatment? ◯ Yes ◯ No

When? ______________ Where? ______________

35. Have you had recent dental treatment? ◯ Yes ◯ No

If yes, when? ______________

Where? ______________

36. Describe your past dental treatment in general.

37. Have you ever had x-rays taken of your jaw joints? ◯ Yes ◯ No

When? ______________ Where? ______________

38. List the names of all the health professionals you have seen for treatment of this problem, chronologically.

A. ______________ E. ______________

B. ______________ F. ______________

C. ______________ G. ______________

D. ______________ H. ______________

39. Discuss the relative success of your prior treatment(s).

40. List all medications you are (a) now taking, (b) have taken for this problem.

______________ ______________

______________ ______________

______________ ______________

41. Please comment on your nutrition.

42. Do you use vitamins? ◯ Yes ◯ No

If yes, name and give dosage. ______

43. Do you smoke? ◯ Yes ◯ No

How much? ______

44. Comment on your sleep patterns: Such as – time you go to sleep, sleep positions, amount of sleep, etc.

45. Are you afraid your problem is serious? ◯ Yes ◯ No

46. Any ideas as to what should be done?

47. **Your medical history:**

a. Are you under current medical care? ◯ Yes ◯ No

If yes, for what? ______

b. Any major illness or operations? ◯ Yes ◯ No

What? ______

When? ______

c. Are you now taking any drugs or medications other than what you might have mentioned in question #40? ◯ Yes ◯ No

If yes, please note. ______

d. Do you have any adverse reactions to drugs? ◯ Yes ◯ No

If yes, please note. ______

e. Do you consider yourself in good health? ◯ Yes ◯ No

Please comment

48. Please add to the above information if you wish.

Signature: ______ Date: ______