

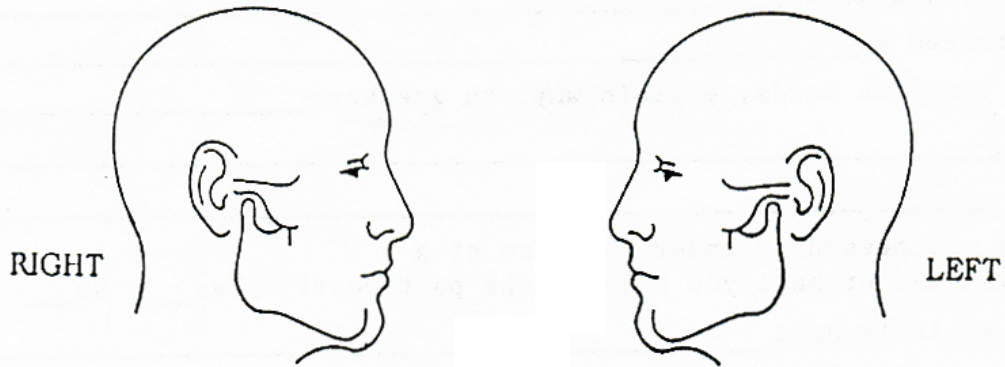
TMJ PATIENT HISTORY FORM

1. Name _____ Date of Birth _____
 Address _____
 City, State, Zip _____
 Referred by _____
2. In your own words, explain why you are here _____

3. 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 you are taking _____
4. Dentist's name _____
 Date of last dental appointment _____
 Treatment prescribed _____
5. Do you have any problems with your jaw? Yes ___ No ___
 If yes, please describe _____
 How long have you had these problems? _____
6. Have you received treatment for jaw problems? Yes ___ No ___
 Who directed this treatment? _____

What was the treatment? (Please indicate below)			RESULTS		
	YES	NO	GOOD	FAIR	POOR
Bite splint.....	___	___	___	___	___
Medication.....	___	___	___	___	___
Physical therapy.....	___	___	___	___	___
Occlusal adjustment.....	___	___	___	___	___
Orthodontics.....	___	___	___	___	___
Counseling.....	___	___	___	___	___
Surgery.....	___	___	___	___	___
Other.....	___	___	___	___	___

7. On the figures below: Mark an X where you have pain
Circle the X where pain is most severe



- When do you have this pain? _____
8. Do you do anything now to relieve your pain? Yes___ No___
If yes, what? _____
9. Are you aware of anything that makes your pain worse? Yes___ No___
If yes, what? _____
10. Do your jaw joints make noises? Yes___ No___
RIGHT Clicking___ Popping___ Grinding___ Other_____
LEFT Clicking___ Popping___ Grinding___ Other_____
11. Has you jaw ever locked open? Yes___ No___
When did this occur? _____
How often has this occurred? _____
12. Has you jaw ever locked closed or partly closed? Yes___ No___
When did this first occur? _____
How often has this occurred? _____
13. Have you ever injured your jaws? Yes___ No___
When? _____
Please describe the injury _____
14. Do you consider yourself to be under more stress than most
people? Yes___ No___
15. Please provide any additional information you feel may be helpful in the
diagnosis or treatment of your condition.

