Adams Orthodontics

A SMILE THAT'S GOOD FOR YOUR LIFE

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HISTORY FORM FOR TEMPOROMANDIBULAR DISORDER

Name:_____ Date:_____

Describe what you think the problem is;
What do you think caused this problem;
Are you presently under care of a physician or have you been in the last year? YES NO
Physician's name_____ Condition treated
Name of medication(s) you are currently taking:
If you have had any major dental treatment in the last two years; please circle;
Orthodontics Periodontics Oral Surgery Restorative
Date(s) of the Third Molar (wisdom tooth) extraction(s)
Do any of you activities hold your head or jaw in an imbalanced position?
(Phone, computer work, swimming, musical instrument) Describe:

Do you sleep with an unusual head position? YES NO DO NOT KNOW
Are you aware of any habits or activities that may aggravate this condition?
Describe:
What can you do to make your pain worse? _____

CURRENT STRESS FACTORS: (Please circle each factor that applies to you)

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	Marital Separation

Other;_____

SYMPTOMS:
(Circle each symptom that applies)

HEAD PAIN, HEADACHES, FACIAL PAIN
Forehead L R
Temples L R
Migraine Type Headaches
Maxillary Sinus Headaches (under the eyes)
Cluster Headaches
Occipital Headaches (back of the head)
Hair and/or Scalp Painful to Touch

EYE PAIN
Eye Pain- Above, below or behind
Burring of Vision
Drooping of the Eyelids
Light Sensitivity
Pressure behind the Eyes

EAR PROBLEMS
Hissing, Buzzing, Ringing, Roaring Sounds.
Ear Pain without infection
Clogged, Stuffy, Itchy Ears
Balance Problems- Vertigo'
Diminished Hearing

NECK AND SHOULDER PAIN
Tired, Sore Neck Muscles
Back Pain, Upper and Lower
Arm and Finger Tingling
Shoulder Aches

OTHER PAIN? If so, please describe:

Is there any additional information that can help us?

Disc Problems

Have you heard popping or clicking sounds in your ears	Yes	No
Has the popping or clicking stopped	Yes	No
Do you hear grinding sounds in your ears	Yes	No
Do you have pain in front of your ears when you bite down	Yes	No
Do you have pain in front of your ears when opening your mouth	Yes	No
Do you have pain in front of your ears when not using your jaw	Yes	No
Does your jaw only open part way (When did it first happen, how often)	Yes	No
When the jaw only opens part way, can you manipulate it to open fully	Yes	No
Does your jaw open and then not close	Yes	No

Muscle Problems

Does your jaw only open part way	Yes	No
Does the amount you can open vary from week to week	Yes	No
Do you have pain below your ear(s) when you bite down	Yes	No
Does it hurt in your temples when you bite down	Yes	No
Do you have neck aches of difficulty turning your head	Yes	No
Do you have headaches	Yes	No
Do you have shoulder or hack problems	Yes	No
Do you clench or grind your teeth	Yes	No
Do you chew gum	Yes	No
Do you awaken at night with facial pain	Yes	No
When you cant open your mouth fully, is it mostly in the morning	Yes	No
Does your jaw pain seem worse in the morning	Yes	No
Does your jaw pain seem worse in the afternoon	Yes	No
Does stress affect any of the above symptoms	Yes	No
Are you in an emotional or stressful period of life	Yes	No
Do you have ulcers, stomach trouble or bowel problems	Yes	No

Airway

Do you have difficulty breathing through your nose	Yes	No
Do you have allergies	Yes	No
Do you have difficulty closing your lips	Yes	No
Have your tonsils and/or adenoids been removed	Yes	No
Do you have speech clarity problems	Yes	No

Progressive Condylar Resorption

Has your bite changed	Yes	No
Has your chin moved backwards	Yes	No
Have you heard popping sounds in your ear(s)	Yes	No
Has the popping stopped	Yes	No
Does your jaw only open part way	Yes	No
Do your teeth hit unevenly	Yes	No
Do you posture your lower face forward	Yes	No
Do you clench or grind your teeth	Yes	No
Have you injured your face, head, neck or jaw	Yes	No
Do you have arthritis	Yes	No
Are any of your other joints painful, swollen or stiff	Yes	No
Have you had rheumatic or scarlet fever	Yes	No
Women; are you or could you be pregnant	Yes	No
Do you take birth control pills	Yes	No
Do you take hormone replacements or steroids	Yes	No

Chronology

Have your symptoms increased or worsened	Yes	No
Do you attribute the symptoms to one incident	Yes	No
When did you first notice your problems; date;	Yes	No

What do you do to control your symptoms: *hot/cold packs, physical therapy/ chiropractor, diet change, anti-inflammatory pain medication, limit your jaw movements, injections*
Whom have you consulted about this: *physiotherapist, chiropractor, TMJ specialist, pain clinic, oral surgeon, orthodontist, general dentist, ENT, neurologist, other.*
Have you had treatment: *splint equilibration (grinding of the teeth), physical therapy/ chiropractic, occlusal reconstruction, orthodontics, TMJ surgery, jaw surgery, stress counseling, other.*