TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth/Age: _____

Sex: M or F (circle one) SSN or SIN: _____

Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____

CHIEF COMPLAINT(S)

1) Describe what you think the problem is: _____

2) What do you think caused this problem? _____

3) Describe, in order (first to last), what you expect from your treatment: _____

MEDICAL AND DENTAL HISTORY

1) Are you presently under the care of a physician or have you been in the past year? Yes ☐ No ☐

Physician's name: _____ Condition(s) treated: _____

TREATMENT

Name of medication(s) you are currently taking: _____

2) How would you describe your overall physical health? (circle one) Poor Average Excellent

3) How would you describe your dental health? (circle one) Poor Average Excellent

Dentist's name: _____ Date of last appointment: _____

4) Have you had any major dental treatment in the last two years? (circle one) Yes ☐ No ☐

If yes, please mark procedure(s): Orthodontics ☐ Periodontics ☐ Oral Surgery ☐ Restorative ☐

Date(s) of Third Molar (wisdom tooth) extraction(s): _____

HISTORY OF INJURY AND TRAUMA

1) Is there any childhood history of falls, acidents of injury to the face of head? Yes ☐ No ☐

Describe: _____

2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)

Yes ☐ No ☐ Describe: _____

3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)

Yes ☐ No ☐ Describe: _____

FACIAL PAIN PAST TREATMENT

1) Have you ever been examined for a TMD problem before? Yes ☐ No ☐

If yes, by whom? When? _____

2) What was the nature of the problem? (Pain, noise, limitation of movement): _____

3) What was the duration of the problem? Months? Years? _____

Is this a new problem? Yes ☐ No ☐

4) Is the problem getting better, worse or staying the same? _____

5) Have you ever had physical therapy for TMD? Yes ☐ No ☐ If yes, by whom? When? _____

6) Have you ever received treatment for jaw problems? Yes ☐ NO ☐ If yes, by whom? When? _____

What was the treatment? (Please mark Below)

Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics
Counseling Surgery

Other ☐ (Please explain): _____

7) Have you ever had injections for your TMD with muscle relaxants (Botox, Flexeril) cortisone or anti-inflammatories?

Yes ☐ No ☐ If yes, were they effective? Yes ☐ No ☐

How many dental appliances have you worn? _____

8) Were these appliances effective? Yes ☐ No ☐

11) Is there any additional information that can help us in this area? _____

CURRENT STRESS FACTORS (PLEASE MARK EACH FACTOR THAT APPLIES TO YOU)

☐ Death of a Spouse	☐ Major Illness or Injury	☐ Major Health Change in Family
☐ Business Adjustment	☐ Divorce	☐ Pending Marriage
☐ Financial Problems	☐ Pregnancy	☐ Career Change
☐ Fired from Work	☐ Marital Reconcilliation	☐ Debt
☐ Death of a Family Member	☐ New Person Joins Family	☐ Marital Separation

CURRENT AND PREVIOUS HABITS (PLEASE MARK YOUR ANSWER TO EACH QUESTION)

1) Do you clench your teeth together under stress?.....Yes ☐ No ☐ Don't Know ☐

2) Do you grind/clench your teeth at night?.....Yes ☐ No ☐ Don't Know ☐

3) Do you sleep with an unusual head position?.....Yes ☐ No ☐ Don't Know ☐

4) Are you aware of any habits or activities that may aggravate this condition?.....Yes ☐ No ☐ Don't Know ☐

Describe: _____

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES)

A. HEAD PAIN, HEADACHES, FACIAL PAIN

Forehead L R

Temples L R

- ☐ Migraine Type Headaches
- ☐ Cluster Headaches Maxillary Sinus
- ☐ Headaches (under the eyes)
- ☐ Occipital Headaches (back of the head with or without shooting pain)
- ☐ Hair and/or Scalp Painful to Touch

B. EYE PAIN / EAR ORBITAL PROBLEMS

- ☐ Eye Pain - Above, Below or Behind
- ☐ Bloodshot Eyes
- ☐ Blurring of Vision
- ☐ Bulging Appearance
- ☐ Pressure Behind the Eyes
- ☐ Light Sensitivity
- ☐ Watering of the Eyes
- ☐ Drooping of the Eyelids

C. MOUTH, FACE, CHEEK & CHIN PROBLEMS

- ☐ Discomfort
- ☐ Limited Opening
- ☐ Inability to Open Smoothly

D. TEETH & GUM PROBLEMS

- ☐ Clenching, Grinding at Night
- ☐ Looseness and/or Soreness of Back Teeth
- ☐ Tooth Pain

E. JAW & JAW JOINT (TMD) PROBLEMS

- ☐ Clicking, Popping Jaw Joints
- ☐ Grating Sounds
- ☐ Jaw Locking Opened or Closed
- ☐ Pain in Cheek Muscles
- ☐ Uncontrollable Jaw/ Tongue Movements

F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES

- ☐ Hissing, Buzzing, or Ringing Sounds
- ☐ Ear Pain without Infection
- ☐ Clogged, Stuffy, Itchy Ears
- ☐ Balance Problems – "Vertigo"
- ☐ Diminished Hearing

G. NECK & SHOULDER PAIN

- ☐ Arm and Finger Tingling, Numbness, Pain
- ☐ Reduced Mobility and Range of Motion
- ☐ Stiffness
- ☐ Neck Pain
- ☐ Tired, Sore Neck Muscle
- ☐ Back Pain, Upper and Lower
- ☐ Shoulder Aches

H. THROAT PROBLEMS

- ☐ Swallowing Difficulties
- ☐ Tightness of Throat
- ☐ Sore Throat
- ☐ Voice Fluctuations

I. OTHER PAIN

_____

_____

_____

_____

_____

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED

NO PAIN MODERATE PAIN SEVERE PAIN

1) Degree of current TMD pain: 0 1 2 3 4 5 6 7 8 9 10

2) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually After Eating

Is the pain constant, continuous, or intermittent? _____ How long does it last? _____

What is the quality of the pain? Sharp, dull, burning, aching, electircal, etc. _____

What makes it worse? _____

What makes it better? _____

How often does the pain occur? _____

Does the pain occur on it's own or do you need to trigger with function, touching, etc.? _____

If you were to place a Q-tip in your left ear and push forward, does that trigger pain? _____

_____

Can the pain be triggered by touching the skin with a light brush stroke with a Q-tip or pressing on an area with a Q-tip? _____

_____

3) Are you taking medication for the TMD problems? Yes ☐ No ☐ If so, what type? _____

_____

How long? _____ Who prescribed the medication? _____

4) Are the medications that you take effective? Yes ☐ No ☐ Conditional? _____

5) Are you aware of anything that makes your pain worse? Yes ☐ No ☐ If yes, what? _____

_____

6) Does your jaw make noise? Yes ☐ No ☐ If so, when and how? _____

Right ☐ Clicking/Popping ☐ Grinding ☐ Other ☐ _____

Left ☐ Clicking/Popping ☐ Grinding ☐ Other ☐ _____

7) Does your jaw lock open? Yes ☐ No ☐ If yes, when did this first occur? _____

How often? _____

8) Has your jaw ever locked closed or partly closed? Yes ☐ No ☐ If yes, when did this first occur? _____

How often? _____

9) Have any dental appliances been prescribed? Yes ☐ No ☐

If yes, by whom? _____

When? _____ Describe: _____

When do you wear your dental appliances? _____

_____ _____

Patient Signature Date