Aesthetic Dentistry of Palm City
"Commitment to Excellence"

Welcome

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 the 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? (circle one) Yes No

Physician's Name _____ Condition(s) Treated _____

_____

TREATMENT

1.) 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 Name: _____ Date of Last Appointment: _____

4.) Have you had any major treatment in the past 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, accidents or injury to the face or head? (circle one) 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? (circle one) 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? (circle one) Yes No

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

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

_____

6.) Have you ever received treatment for jaw problems? (circle one) Yes No If yes, by whom? When? _____

_____

What was the treatment? (circle one) Bite Splint Medication Physical Therapy Occlusal Adjustment

Counseling Surgery Other (Please explain) _____

7.) Have you ever had injections for your TMD with muscle relaxants (Botox, Lidocaine, Cortisone)? Yes No

If yes, were they effective? (circle one) Yes No

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED (please circle)

	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? (circle one) Sharp Dull Burning Aching Electrical Other _____

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? (circle one) Yes No If yes, what type? _____

How long? _____ Who prescribed the medication? _____

4.) Are the medications that you take effective? (circle one) Yes No Conditional? _____

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

_____

6.) Does your jaw make noise? (circle one) Yes No If so, when and how? _____

Right Side ☐ Clicking/Popping ☐ Grinding ☐ Other _____

Left Side ☐ Clicking/Popping ☐ Grinding ☐ Other _____

7.) Does your jaw lock open? (circle one) Yes No If so, when did this first occur? _____

How often? _____

8.) Has your jaw ever locked closed or partly closed? (circle one) Yes No If so, when did this first occur? _____

How often? _____

9.) Have any dental appliances been prescribed? (circle one) Yes No If so, by whom? _____

When? _____ Describe: _____

When do you wear your dental appliances? _____

How many dental appliances have you worn? _____

10.) Are these appliances effective? (circle one) 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 Reconciliation	☐ Taking on Debt
☐ Death of a Family Member	☐ New Person Joins Family	☐ Marital Separation

☐ Other _____

CURRENT AND PREVIOUS HABITS (PLEASE CIRCLE 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

☐ Migrain 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 the 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

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES) continued

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

H. THROAT PROBLEMS

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

I. OTHER PAINS

_____

_____

_____

_____

_____

_____