



American Association of  
Orthodontists

# HISTORY FORM FOR PATIENT WITH TEMPOROMANDIBULAR DISORDER

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name Dr. Mr. Mrs. Ms. Miss \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_  
Referred by \_\_\_\_\_

## MAJOR REASON FOR CURRENT EVALUATION:

- 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: \_\_\_\_\_

## GENERAL 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 treated \_\_\_\_\_  
Treatment \_\_\_\_\_  
Name of medication(s) you are currently taking \_\_\_\_\_
- 2) How would you describe your overall physical health? 

|   | Poor | Average         | Excellent |
|---|------|-----------------|-----------|
| 0 | 1    | 2 3 4 5 6 7 8 9 | 10        |
- 3) How would you describe your dental health? 

|   | Poor | Average         | Excellent |
|---|------|-----------------|-----------|
| 0 | 1    | 2 3 4 5 6 7 8 9 | 10        |

  
Dentist's name \_\_\_\_\_ Date of last appointment \_\_\_\_\_
- 4) Have you had any major dental treatment in the last two years? YES NO  
If yes, please circle procedure(s) Orthodontics Periodontics Oral Surgery Restorative  
Date(s) of Third Molar (wisdom tooth) extraction(s) \_\_\_\_\_

## FACIAL INJURY/TRAUMA HISTORY:

- 1) Is there any childhood history of falls, accidents or injury to the face or head?  
Describe: \_\_\_\_\_
- 2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)  
Describe: \_\_\_\_\_
- 3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)  
Describe: \_\_\_\_\_

## TMD TREATMENT HISTORY:

- 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 circle below)  
Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics Counseling Surgery  
Other (Please explain) \_\_\_\_\_

## CURRENT MEDICATIONS/APPLIANCES:

- |   | 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          |
| Is there a pattern related to pain occurrence?  | Upon Waking | Morning           | Afternoon Evening After Eating |
| 3) Are you taking medication for the TMD problem? If so, what type?<br>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  
 RIGHT Clicking Popping Grinding Other \_\_\_\_\_  
 LEFT Clicking Popping Grinding Other \_\_\_\_\_
- 7) Does your jaw lock open? YES NO When did this first occur? \_\_\_\_\_ How often? \_\_\_\_\_
- 8) Has your jaw ever locked closed or partly closed? YES NO  
 When did this first occur? \_\_\_\_\_ How often? \_\_\_\_\_
- 9) Have any dental appliances been prescribed? YES NO  
 If yes, by whom? \_\_\_\_\_ When? \_\_\_\_\_  
 Describe \_\_\_\_\_
- 10) Are these appliances effective? YES NO
- 11) Is there any additional information that can help us in this area? \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Death of Spouse        | <input type="checkbox"/> Major Illness or Injury | <input type="checkbox"/> Major Health Change in Family |
| <input type="checkbox"/> Business Adjustment    | <input type="checkbox"/> Divorce                 | <input type="checkbox"/> Pending Marriage              |
| <input type="checkbox"/> Financial Problems     | <input type="checkbox"/> Pregnancy               | <input type="checkbox"/> Career Change                 |
| <input type="checkbox"/> Fired from Work        | <input type="checkbox"/> Marital Reconciliation  | <input type="checkbox"/> Taking on Debt                |
| <input type="checkbox"/> Death of Family Member | <input type="checkbox"/> New Person Joins Family | <input type="checkbox"/> Other                         |
| <input type="checkbox"/> Marital Separation     |  |  |

**HABIT HISTORY: (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 \_\_\_\_\_

**SYMPTOMS: (Circle each symptom that applies)**

- |  |  |   |
|--|--|---|
| <p>A. HEAD PAIN, HEADACHES, FACIAL PAIN</p> <p>Forehead L R<br/>         Temples L R<br/>         Migraine Type Headaches<br/>         Cluster Headaches<br/>         Maxillary Sinus Headaches (under the eyes)<br/>         Occipital Headaches (back of the head with or without shooting pain)<br/>         Hair and/or Scalp Painful to Touch</p> <p>B. EYE PAIN OR EAR ORBITAL PROBLEMS</p> <p>Eye Pain – Above, Below or Behind<br/>         Bloodshot Eyes<br/>         Blurring of Vision<br/>         Bulging Appearance<br/>         Pressure Behind the Eyes<br/>         Light Sensitivity<br/>         Watering of the Eyes<br/>         Drooping of the Eyelids</p> <p>C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS</p> <p>Discomfort<br/>         Limited Opening<br/>         Inability to Open Smoothly</p> | <p>D. TEETH AND GUM PROBLEMS</p> <p>Clenching, Grinding at Night<br/>         Looseness and/or Soreness of Back Teeth<br/>         Tooth Pain</p> <p>E. JAW AND JAW JOINT (TMD) PROBLEMS</p> <p>Clicking, Popping Jaw Joints<br/>         Grating Sounds<br/>         Jaw Locking Opened or Closed<br/>         Pain in Check Muscles<br/>         Uncontrollable Jaw/Tongue Movements</p> <p>F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES</p> <p>Hissing, Buzzing, Ringing or Roaring Sounds<br/>         Ear Pain without Infection<br/>         Clogged, Stuffy, Itchy Ears<br/>         Balance Problems — “Vertigo”<br/>         Diminished Hearing</p> <p>G. OTHER PAIN</p> <p>If so, please describe: _____</p> | <p>H. THROAT PROBLEMS</p> <p>Swallowing Difficulties<br/>         Tightness of Throat<br/>         Sore Throat<br/>         Voice Fluctuations<br/>         Laryngitis<br/>         Frequent Coughing/Clearing Throat<br/>         Feeling of Foreign Object in Throat<br/>         Tongue Pain<br/>         Salivation<br/>         Pain in the Hard Palate</p> <p>I. NECK AND SHOULDER PAIN</p> <p>Reduced Mobility and Range of Motion<br/>         Stiffness<br/>         Neck Pain<br/>         Tired, Sore Neck Muscles<br/>         Back Pain, Upper and Lower Shoulder Aches<br/>         Arm and Finger Tingling, Numbness, Pain</p> |
|--|--|---|

On the figures below, mark an “X” where you have pain. Circle the “X” where the pain is most severe.

