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History Form for Patient with Temporomandibular Disorder

Date_____

Name_____Birth date_____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems?_____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems	**Left**		**Right**		
Joint clicking or popping	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Grating noises	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Jaw locks open	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Jaw locks closed	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Limited jaw opening	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Jaw does not open smoothly	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Soreness of jaw joints	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Soreness of face muscles	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____

Teeth Problems					
Teeth grinding	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Teeth clenching	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Soreness of one or more teeth	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____
Looseness of one or more teeth	☐ Yes	☐ No	☐ Yes	☐ No	Comments _____

Head and Facial Pain	**Left**		**Right**		**(least)**				**Degree of Pain**						**(most)**
Migraine type headache	☐ Yes	☐ No	☐ Yes	☐ No	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Cluster headaches	☐ Yes	☐ No	☐ Yes	☐ No	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Sinus headaches	☐ Yes	☐ No	☐ Yes	☐ No	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Headaches in back of head	☐ Yes	☐ No	☐ Yes	☐ No	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Hair and/or scalp painful to touch	☐ Yes	☐ No	☐ Yes	☐ No	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Ear or Balance Problems			
Pain in ear	☐ Yes	☐ No	Comments _____
Ringing or buzzing	☐ Yes	☐ No	Comments _____
Clogged or stuffy ears	☐ Yes	☐ No	Comments _____
Diminished hearing	☐ Yes	☐ No	Comments _____
Dizziness or vertigo	☐ Yes	☐ No	Comments _____
Poor sense of balance	☐ Yes	☐ No	Comments _____