TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth/Age: _____

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: _____

_____

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

1) 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, accidents 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: _____

5) Have you ever been sedated (put to sleep) for surgery? Yes ☐ If yes, when? _____ No☐

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 your pain in the morning, afternoon, or night? _____

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

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

7) 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): _____

8) 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? _____

9) Were these appliances effective? Yes ☐ No ☐

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

11) What makes it worse? _____

12) What makes it better? _____

CURRENT MEDICATIONS

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? _____

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

_____.

How long? _____ Who prescribed the medication? _____

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

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 Other

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

1) Do you clench your teeth together under stress?.....Yes ☐ No ☐
2) Do you grind/clench your teeth at night?.....Yes ☐ No ☐
3) Do you sleep with an unusual head position?.....Yes ☐ ☐
4) Are you aware of any habits or activities that may aggravate this condition?.....Yes ☐ No ☐

Describe: _____

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES)

	Degree of Pain	Frequency	Time of Day
	0 – No Pain 1 – Mild 2 – Moderate 3 – Severe	A) Daily B) Monthly C) Yearly	1 - Morning 2 - Afternoon 3 - Night
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			
☐ Drooping of Eyelids			
☐ Pressure Behind the Eyes			
☐ Light Sensitivity			
☐ Watering of the Eyes			
C. JAW & JAW JOINT (TMD) PROBLEMS			
☐ Clicking, Popping Jaw Joints			
☐ Grating Sounds			
☐ Jaw Locking Opened			
☐ Jaw Locking Closed			
☐ Uncontrollable Jaw/ Tongue Movements			
☐ Pain in Cheek Muscles			
D. PAIN, EAR PROBLEMS, POSTURAL IMBALAN			
☐ Hissing, Buzzing, or Ringing Sounds			
☐ Ear Pain without Infection			
☐ Clogged, Stuffy, Itchy Ears			
☐ Balance Problems – "Vertigo"			
☐ Diminished Hear			

	Degree of Pain	Frequency	Time of Day
	0 – No Pain 1- Mild 2- Moderate 3- Severe	A) Daily B) Monthly C) Yearly	1- Morning 2- Afternoon 3- Night

E. 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			

F. THROAT PROBLEMS

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

Possible Complications

Some people may not be able to tolerate the appliances in their mouths. Also, some individuals will develop temporary adverse side effects such as excessive salivation, sore jaw joints, sore teeth and a slight change in their "bite", However, these usually diminish within an hour after appliance removal in the morning. On a rare occasion, a permanent "bite" change may occur due to jaw joint changes and/or tooth movement. Generally, this can be prevented with modifications to the appliance. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative, orthodontic, and/or surgical treatment may be required, for which you are responsible. Oral appliances can wear and break. The rare possibility that these or broken parts from them may be swallowed or aspirated exists. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use is a hazard to your health and can lead to a heart attack, or stroke, and even death. See your prescriber before discontinuing use and for recommendations of alternative therapy such as CPAP and/or surgery.

Signature_____ Date_____