



American Academy of Facial Esthetics TMD Health History Form

Patient's Name: _____

Date of Birth: _____

Age: _____

Sex: Male Female

S.S.N. /S.I.N.: _____

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 0 1 2 3 **Average** 4 5 6 7 **Excellent** 8 9 10

3) How would you describe your dental health?

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 mark 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? YES NO

Describe: _____

2) Is there any recent history of trauma to the head or face? YES NO

Describe: _____

3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming) YES NO

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? _____



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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®, Flexoril) cortisone or anti-

inflammatories? _____ Were they effective: Yes NO

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

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 select all applicable)

Death of 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 Family Member New Person Joins Family Other

Marital Separation

HABIT HISTORY: (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

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
- Jaw Locking Opened or Closed

B. EYE PAIN OR 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
- Balance Problems – “Vertigo”

C. MOUTH, FACE, CHEEK AND CHIN PROBLEMS

- Discomfort
- Limited Opening
- Inability to Open Smoothly

D. TEETH AND GUM PROBLEMS

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

E. JAW AND JAW JOINT (TMD) PROBLEMS

- Clicking, Popping Jaw Joints
- Grating Sounds
- Pain in Cheek Muscles
- Uncontrollable Jaw/Tongue Movements

F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES

- Hissing, Buzzing, Ringing or
- Roaring Sounds
- Ear Pain without Infection
- Clogged, Stuffy, Itchy Ears
- Pain
- Diminished Hearing
- Pain

H. THROAT PROBLEMS

- Swallowing Difficulties
- Tightness of Throat
- Sore Throat
- Voice Fluctuations
- Laryngitis
- Frequent Coughing/Clearing Throat
- Feeling of Foreign Object in Throat
- Tongue Pain
- Salivation
- Pain in the Hard Palate

I. NECK AND SHOULDER PAIN

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

G. OTHER PAIN

- If so, please describe: _____

