Gainesville
Oral and Maxillofacial Surgery

TMJ Patient History Form

Name: _____

Date: _____

Please answer all questions in detail.

1. Do you have any problems with your jaw? _____ Yes _____ No If yes, please describe in detail _____

_____

How long have you had these problems? _____

2. Have you received treatment for these problems? _____ Yes _____ No

Who directed this treatment? _____

3. What was the treatment? (Please indicate)

	Upper Hard Lower Soft	**Results** **Good**	**Fair**	**Poor**
Bit splint	_____	_____	_____	_____
Medication	_____	_____	_____	_____
Physical therapy	_____	_____	_____	_____
Occlusal adjustment	_____	_____	_____	_____
Orthodontics	_____	_____	_____	_____
Counseling	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Other	_____	_____	_____	_____

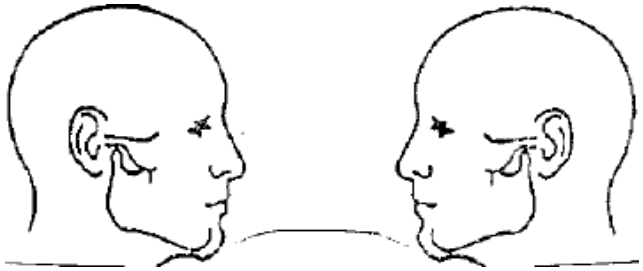
4. On the figures to the right, place a circle where you have pain and place a small dot where the pain is most severe.

5. Do you have frequent ….

… headaches? _____

… neck aches? _____

… shoulder aches? _____

Right  Left

6. When do you have this pain (morning, night, during eating, etc.)? _____

7. Do you do anything now to relieve your pain, i.e., heat, soft diet, Advil? _____ Yes _____ No

If yes, what? _____

8. Are you aware of anything that makes your pain worse, i.e. chewing hard food, yawning? _____ Yes _____ No

If yes, what? _____

9. Do your jaw joints make noise? _____ Yes _____ No If yes, how long has this been occurring? _____

Is the noise loud enough for others to hear? _____ Yes _____ No

Right:	Clicking	_____	Popping	_____	Grinding	_____
Left:	Clicking	_____	Popping	_____	Grinding	_____

10. Has your jaw ever locked open (where you cannot close your mouth)? _____ Yes _____ No

If yes, for how long? _____ When did this first occur? _____ How often has this occurred? _____

11. Has you jaw ever locked closed or partially closed (where you cannot open your mouth)? _____ Yes _____ No

If yes, for how long? _____ When did this first occur? _____ How often has this occurred? _____

12. Have you ever injured your jaws/face/neck? _____ Yes _____ No

If yes, when? _____ Please describe the injury _____

13. Do you feel you are under any stress? _____ Yes _____ No If yes, why? _____

_____

14. Do you clinch or grind your teeth at night? _____