TMJ History

Date___________________________

Name____Age_______Date of Birth___________________Sex______

Occupation____Who referred you?__________________________________

Do you have clicking, grating or popping noise in the joint? Yes No If yes, which side? Right Left

When did you first notice the noise?____

____

Has the noise become more pronounced recently?____

When?____

Do you have pain in or around the joint? Yes No If yes, which side? Right Left

When is the pain worse? Mornings evenings at meals no specific time other__________________

Describe the pain: dull stabbing throbbing continuous intermittent other__________________

Does the pain feel like it is in your ear? Yes No If yes, which side? Right Left

When did you first notice the pain?____

Has the pain recently become more pronounced? Yes No When?____________________________________

Does your joint problem interfere with your work and other normal activities? Yes No

Are you presently taking or have you ever taken medications for this problem? Yes No

If yes, what?____ _____________________________________

Have you had any injury to the face which might have contributed to this condition? Yes No

If yes, please explain:____

Have you had problems with other joints? Yes No If yes, which joints?________________________________

Do you have difficulty chewing? Yes No

If yes, is it because of: Pain in joint Missing teeth Pain in teeth

Limited opening Clicking Other___________________________

Is your jaw ever stiff? Yes No

If yes, when: mornings evenings at meals no specific time other____________

Has your mouth ever locked open so you were unable to close it? Yes No

If yes, how often?____

Have you ever had episodes where your jaw would not open or was limited in opening? Yes No

If yes, when?____

Do you think your joint problem has affected your hearing? Yes No

Please number the following problems in the sequence of the time in which you became aware of them. Number only those problems which you have had in the past or have now:

_______Pain

_______Noise

_______Limited opening

_______Other_______________________________

Are you aware of clenching your teeth? Yes No

Are you aware or have others told you that you grind your teeth? Yes No

How does your nervous tension seem to affect your joint problem?____

____

Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death of a loved one or other stressful events?____

____

Have you had orthodontic treatment? Yes No When?____

Have you had x-rays or any imaging done for this joint problem? Yes No

If yes, when and where?____

Have you received any previous treatment for this condition? Yes No

If yes, when and where?____

Which aspect of your problem concerns you the most?____

____

Patient/Parent Signature____Date____________________