American Association of Orthodontists

HISTORY FORM FOR PATIENT WITH TEMPOROMANDIBULAR DISORDER

Date ______________________ Date of Birth ______________________
Name Dr. Mr. Mrs. Ms. Miss ______________________
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 ______________________

	Poor			Average				Excellent			
2) How would you describe your overall physical health?	0	1	2	3	4	5	6	7	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 circle 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?
   Describe: ______________________
2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)
   Describe: ______________________
3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)
   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?
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 circle below)
   Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics Counseling Surgery
   Other (Please explain) ______________________

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
3) Are you taking medication for the TMD problem? If so, what type? ______________
   How long? ______________ Who prescribed the medication? ______________
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? ______________

(CONTINUED ON REVERSE SIDE)

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Address ______________________
City ______________________ State/Province ____________ Zip/Postal Code ____________
Referred by ______________________

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1) Describe what you think the problem is: ______________________
2) What do you think caused this problem? ______________________
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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 ______________________

	Poor	Average	Excellent
2) How would you describe your overall physical health?	0 1 2 3 4 5 6 7 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 circle 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?
Describe: ______________________
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Describe: ______________________
3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)
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
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If yes, by whom? ______________________ When? ______________________
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If yes, by whom? ______________________ When? ______________________
What was the treatment? (Please circle below)
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Other (Please explain) ______________________

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