

# TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_

Sex: M or F (circle one) SSN or SIN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

## 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: \_\_\_\_\_

## MEDICAL AND DENTAL 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(s) treated: \_\_\_\_\_

## TREATMENT

Name of medication(s) you are currently taking: \_\_\_\_\_

2) How would you describe your overall physical health? (circle one) Poor Average Excellent

3) How would you describe your dental health? (circle one) Poor Average Excellent

Dentist's name: \_\_\_\_\_ Date of last appointment: \_\_\_\_\_

4) 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: \_\_\_\_\_

## 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 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 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, Flexeril) cortisone or anti-inflammatories?

Yes  No  If yes, were they effective? Yes  No

How many dental appliances have you worn? \_\_\_\_\_

8) Were these appliances effective? Yes  No

11) Is there any additional information that can help us in this area? \_\_\_\_\_

### CURRENT STRESS FACTORS (PLEASE MARK EACH FACTOR THAT APPLIES TO YOU)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Death of a Spouse        | <input type="checkbox"/> Major Illness or Injury | <input type="checkbox"/> Major Health Change in Family |
| <input type="checkbox"/> Business Adjustment      | <input type="checkbox"/> Divorce                 | <input type="checkbox"/> Pending Marriage              |
| <input type="checkbox"/> Financial Problems       | <input type="checkbox"/> Pregnancy               | <input type="checkbox"/> Career Change                 |
| <input type="checkbox"/> Fired from Work          | <input type="checkbox"/> Marital Reconciliation  | <input type="checkbox"/> Debt                          |
| <input type="checkbox"/> Death of a Family Member | <input type="checkbox"/> New Person Joins Family | <input type="checkbox"/> Marital Separation            |
| <input type="checkbox"/> Other                    |  |  |

### CURRENT AND PREVIOUS HABITS (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

Describe: \_\_\_\_\_

### CURRENT 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

#### B. EYE PAIN / 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

#### C. MOUTH, FACE, CHEEK & CHIN PROBLEMS

- Discomfort
- Limited Opening
- Inability to Open Smoothly

#### D. TEETH & GUM PROBLEMS

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

#### E. JAW & JAW JOINT (TMD) PROBLEMS

- Clicking, Popping Jaw Joints
- Grating Sounds
- Jaw Locking Opened or Closed
- Pain in Cheek Muscles

- Uncontrollable Jaw/ Tongue Movements

**F. PAIN, EAR PROBLEMS,**

**POSTURAL IMBALANCES**

- Hissing, Buzzing, or Ringing Sounds
  - Ear Pain without Infection
  - Clogged, Stuffy, Itchy Ears
  - Balance Problems – “Vertigo”
  - Diminished Hearing
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**G. 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

**H. THROAT PROBLEMS**

- Swallowing Difficulties
- Tightness of Throat
- Sore Throat
- Voice Fluctuations

**I. OTHER PAIN**

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**CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED**

	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		After Eating		

Is the pain constant, continuous, or intermittent? \_\_\_\_\_ How long does it last? \_\_\_\_\_

What is the quality of the pain? Sharp, dull, burning, aching, electrical, etc. \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How often does the pain occur? \_\_\_\_\_

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? \_\_\_\_\_

3) Are you taking medication for the TMD problems? Yes  No  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? \_\_\_\_\_

6) Does your jaw make noise? Yes  No  If so, when and how? \_\_\_\_\_

Right  Clicking/Popping  Grinding  Other  \_\_\_\_\_

Left  Clicking/Popping  Grinding  Other  \_\_\_\_\_

7) Does your jaw lock open? Yes  No  If yes, when did this first occur? \_\_\_\_\_

How often? \_\_\_\_\_

8) Has your jaw ever locked closed or partly closed? Yes  No  If yes, when did this first occur? \_\_\_\_\_

How often? \_\_\_\_\_

9) Have any dental appliances been prescribed? Yes  No

If yes, by whom? \_\_\_\_\_

When? \_\_\_\_\_ Describe: \_\_\_\_\_

When do you wear your dental appliances? \_\_\_\_\_