TMJ and Orofacial Pain
Medical History Form

In filling out this form it is important to consider your medical history and what treatments or medications you have previously tried. The more information you can provide you increase the chances of an accurate diagnosis.

Patient Information and Health Questionnaire

☐ MR. ☐ MS. ☐MISS ☐ MRS. ☐ DR. **TODAY'S DATE:** _____

PATIENT NAME: _____
First Middle Initial Last

AGE: _____ **DATE OF BIRTH:** _____ ☐ **MALE** ☐ **FEMALE**

ADDRESS: _____ **CITY/STATE/ZIP**: _____

CELL PHONE: _____ **HOME PHONE:** _____

WORK PHONE: _____ **EMAIL:** _____

SS#: _____ **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED

EMERGENCY CONTACT PERSON (NAME AND PHONE #): _____

REFERRED BY: _____ ☐ DDS ☐ MD ☐ENT ☐ DC ☐ OTHER

REASON FOR VISIT

FACIAL PAIN **JAW PAIN** **HEADACHES** ☐ **FATIGUE/BREATHING CONCERNS** ☐ **OTHER:** _____

WHAT ARE YOUR 3 CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
Please mark only 3 main complaints then rate your complaints for **intensity** on a scale of 0-10 with 0 being none and 10 being the worst.

- ■ Jaw Pain 5____
- □ Headache Pain ____
- □ Facial Pain ____
- □ Throat Pain ____
- □ Tooth grinding ____
- □ Jaw Joint Locking ____
- □ Dizziness ____
- □ Kicking and jerking leg repeatedly ____
- □ Fatigue ____
- □ Repeated-awakening ____
- □ Significant daytime drowsiness ____
- □ Told that "I stop breathing" during sleep ____
- ■ Ear Pain ____
- □ Pain when chewing ____
- □ Eye Pain ____
- □ Neck Pain ____
- □ Limited ability to open mouth ____
- □ Jaw Joint Noises ____
- □ Tinnitus (ringing in the ears) ____
- □ Dry Mouth when waking ____
- □ Difficulty falling asleep ____
- □ Feeling unrefreshed in the morning ____
- □ Frequent heavy snoring ____
- □ Unable to tolerate C-Pap ____

MEDICAL HISTORY

WHAT IS YOUR MEDICAL STORY: _____

_____

When did your condition first occur? _____

What do you believe is the cause of your pain or condition?

Pick One:

☐AUTO ACCIDENT ☐MOTORCYCLE ACCIDENT ☐WORK RELATED ACCIDENT

☐ATHLETIC ENDEAVOR ☐FIGHT ☐FALL ☐ACCIDENT ☐ILLNESS ☐INJURY

☐UNKNOWN ☐OTHER:_____

Is there anything that makes your pain or discomfort worse? _____
(Please describe)

Is there anything that makes your pain and discomfort better? _____
(Please describe)

What other information is important to your pain or condition? _____
(Please describe)

_____

ALLERGIC REACTIONS

Please list all medications and check or list the substances that have caused an ALLERGIC REACTION

☐ANESTHETICS ☐IODINE ☐LATEX ☐METALS ☐Other: _____

☐Other: _____ ☐Other: _____ ☐Other: _____

CURRENT MEDICATIONS

☐ Patient medication list attached

Please list all medications you are taking and the reason you take them. Include all over-the-counter medications, vitamins, herbs, etc.

Medication	Dosage	Reason for taking

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment and/or Medication	Doctor/Provider Name	Approximate Date of Treatment

HEALTH AND MEDICAL HISTORY

Have you ever had prior orthodontic treatments? ☐YES ☐NO

Are you currently pregnant? ☐YES ☐NO

Are you currently breastfeeding? ☐YES ☐NO

SURGICAL HISTORY

Have you had your wisdom teeth removed? ☐YES ☐NO

Have you ever had a root canal or any other tooth removal for this condition? ☐YES ☐NO

Have you ever had Jaw Joint Surgery? ☐YES ☐NO

Have you ever had Orthognathic Surgery? ☐YES ☐NO

Any other types of surgery? _____

MEDICAL HISTORY

Please check all that apply and leave all others blank, if there is anything not listed please indicate the information in the OTHER section.

Allergy History

- ☐ Allergy Skin Testing
- ☐ Allergen Desensitization
- ☐ Hay Fever

Eye History

- ☐ Cataract
- ☐ Visual Impairment
- ☐ Glaucoma

Cardiac History

- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Rhythm Disorder
- ☐ Functional Murmur
- ☐ Mitral Valve Prolaspe
- ☐ Angina Pectoris
- ☐ Prior MI
- ☐ Coronary Artery Disease
- ☐ Peripheral Vascular
- ☐ Hypertension

ENT History

- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Turbinectomy

Pulmonary History

- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis

Gastrointestinal History

- ☐ Hepatitis
- ☐ Acute Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Esophageal Reflux
- ☐ Esophageal Ulcer
- ☐ Peptic Ulcer
- ☐ Chronic Reflux Esphagitis
- ☐ Esophagitis
- ☐ Esophageal Stricture
- ☐ Hiatal Hernia

Cancer History

- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Therapy

Infectious Disease

- ☐ Measles
- ☐ Chicken Pox
- ☐ Smallpox
- ☐ Diphtheria

Trauma

- ☐ Facial Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Mouth Injury

Hematological History

- ☐ Anemia
- ☐ Bleeding/Clotting
- ☐ Leukemia
- ☐ HIV

MEDICAL HISTORY Cont.

Please check all that apply and leave all others blank, if there is anything not listed please indicate the information in the OTHER section.

Kidney/Bladder History
- □ Prostate Disorders
- □ Renal Failure
- □ Stress Incontinence
- □ Urinary, Bladder Infections
- □ Kidney Stones
- □ Urinary Calculus

Endocrine History
- □ Diabetes Mellitus
- □ Thyroid Disorders
- □ Chronic Fatigue

Neurological History
- □ Epilepsy
- □ TIA
- □ Stroke Syndrome
- □ Multiple Sclerosis
- □ Depression
- □ Bipolar Disorder
- □ ADHD
- □ Migraine Headaches
- □ Vascular Headaches

Musculoskeletal History
- □ Osteoarthritis
- □ Arthritis
- □ Rheumatoid Arthritis
- □ Osteoporosis
- □ Fibromyalgia

OTHER HISTORY ITEMS NOT LISTED: _____

CURRENT SYMPTOMS

Systemic symptoms
- □ Feeling tired or poorly
- □ Weight change
- □ Chills
- □ Fever

Otolaryngial Symptoms
- □ Mouth sores
- □ Difficulty swallowing (dysphagia)
- □ Difficulty chewing
- □ Dentures currently being worn
- □ Dentures improperly fitting

Head symptoms
- □ Headache
- □ Facial pain
- □ Sinus pain
- □ Tooth pain

Musculoskeletal symptom
- □ Joint pain, localized in the jaw (joint)
- □ Diffuse joint pains (arthralgias)
- □ Joint pain, localized
- □ Joint swelling, localized
- □ Muscle aches
- □ Muscle cramps
- □ Legs feel restless
- □ Other

Neck symptoms
- □ Neck pain
- □ Neck stiffness
- □ Lump or swelling

Gastrointestinal
- □ Appetite
- □ Heartburn
- ■ Nausea
- □ Vomiting
- □ Abdominal pain
- □ Regurgitation
- □ Yellow skin/eyes (jaundice)
- □ Inability to pass gas
- □ Bowel movement frequency
- □ Diarrhea
- □ Unable to control passing gas
- □ Constipation
- □ Rectal Pain

Neurological symptoms
- □ Dizziness
- □ Vertigo
- □ Fainting (syncope)
- □ Motor disturbances
- □ Sensory disturbances
- □ Decreased concentrating ability

Cardiovascular
- □ Chest pain or discomfort
- □ Palpitations
- □ Slow heart rate
- □ Leg pain with exercise
- □ Cold hands/feet

Endocrine
- □ Temperature intolerance
- □ Excessive sweating
- □ Hot flashes
- □ Muscle weakness
- □ Muscle weakness
- □ Sexual complaints
- □ Changes in body proportion
- □ Hair symptoms

CURRENT SYMPTOMS Cont. Please check all that apply and leave all others blank

Psychological symptoms
- ☐ Mood
- ☐ Energy level
- ☐ Behavior
- ☐ Sleep disturbances
- ☐ Neurological symptoms

Skin symptoms
- ☐ Pruritus
- ☐ Skin Lesions
- ☐ Rashes

OTHER SYMPTOMS NOT LISTED: _____

Please check the appropriate boxes, if applicable.

JAW PAIN
L ☐ R ☐ Jaw Pain when opening
L ☐ R ☐ Jaw Pain when chewing
L ☐ R ☐ Jaw Pain at rest

JAW JOINT SOUNDS (Clicking, Crunching, Popping)
L ☐ R ☐ Jaw Sounds when opening
L ☐ R ☐ Jaw Sounds when chewing
L ☐ R ☐ Jaw Sounds at rest

JAW LOCKING
Yes ☐ No ☐ Jaw Locks Closed
Yes ☐ No ☐ Jaw Locks Open

JAW JOINT SYMPTOMS
Yes ☐ No ☐ Teeth Clenching Day ☐ Night ☐
Yes ☐ No ☐ Teeth Grinding Day ☐ Night ☐

EYE RELATED CONDITIONS
Yes ☐ No ☐ Blurred Vision
Yes ☐ No ☐ Double Vision
Yes ☐ No ☐ Eye Pain
Yes ☐ No ☐ Pain or pressure behind the eyes
Yes ☐ No ☐ Extreme Sensitivity to light
Yes ☐ No ☐ Wear Glasses or Contacts

EAR RELATED CONDITIONS

L ☐ R ☐ Buzzing in the ears
L ☐ R ☐ Ear congestion
L ☐ R ☐ Ear pain
L ☐ R ☐ Hearing Loss
L ☐ R ☐ Itching or stuffiness in the ears
L ☐ R ☐ Pain behind the ear
L ☐ R ☐ Pain in front of the ear
L ☐ R ☐ Recurrent ear infections
L ☐ R ☐ Ringing in the ear (Tinnitus)

MOUTH AND NOSE RELATED CONDITIONS

Yes ☐ No ☐ Dry Mouth
Yes ☐ No ☐ Chronic sinusitis
Yes ☐ No ☐ Frequent snoring
Yes ☐ No ☐ Burning tongue
Yes ☐ No ☐ Broken teeth
Yes ☐ No ☐ Frequent biting of the cheek

SLEEP CONDITIONS Please select yes or no answers on your average sleep experience and/or what a sleep partner has told you

Sleep Positions: Side ☐ Back ☐ Stomach ☐ Varies ☐
Is it easy to fall asleep? Yes ☐ No ☐
Do you feel rested upon AM waking? Yes ☐ No ☐
Stopped breathing during sleep? Yes ☐ No ☐

Average hours of sleep per night _____
Do you wake often during the night? Yes ☐ No ☐
Gasping or Choking during sleep? Yes ☐ No ☐
Have you ever had a Sleep Study (PSG)? Yes ☐ No ☐
Result was:_____

Family History

☐ Diabetes Mellitus
☐ Cancer
☐ Loss of Hearing
☐ Allergies
☐ Stroke
☐ Hypertension
☐ Asthma
☐ Heart Disease
☐ CAD – Coronary artery disease
☐ CHF – congestive heart failure
☐ Pulmonary Hypertension
☐ PVD – peripheral vascular disease
☐ Migraine Headache
☐ Cluster Headache
☐ Meniere's Disease
☐ Neurofibromatosis Type 1 (Recklinghausen's Disease)

Social History

☐ Life circumstance event
☐ Caffeine use
☐ Tobacco use
☐ Smoking cigarettes
☐ Alcohol
☐ Drug use
☐ Marijuana use
☐ Occupation _____

Rate the extent to which you have been bothered by the following symptoms since your injury:

	0 Never	1 Occasionally	2 Often or All of the time
1. Difficulty maintaining your concentration	☐	☐	☐
2. Difficulty thinking about anything other than the pain	☐	☐	☐
3. A feeling of being overwhelmed by pain or other symptoms	☐	☐	☐
4. Flashbacks of the accident while you're awake that feel very real	☐	☐	☐
5. Feeling 'wound up', agitated or scared when in a place that reminds you of the accidents (e.g. in a car, at work, or on a slippery surface)	☐	☐	☐
6. Frustration at your inability to control your pain	☐	☐	☐
7. Loss of motivation to get up and start a new day	☐	☐	☐
8. Pain that lasts an entire day without easing	☐	☐	☐
9. Loss of interest in your appearance	☐	☐	☐
10. Difficulty doing the things that you would normally enjoy	☐	☐	☐
11. Feeling 'numb' or disengaged, as if you were watching the world through a window	☐	☐	☐
12. Anger directed at others	☐	☐	☐

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Check one in each row:	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (ex. a theater or a meeting)	☐	☐	☐	☐
As a passenger in a car For an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to Someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total Score: _____

Patient name: _____ Date: _____