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 or 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? __________________________
How many dental appliances have you worn? ________________

10) Are 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)

- ☐ Death of a Spouse
- ☐ Major Illness or Injury
- ☐ Major Health Change in Family
- ☐ Business Adjustment
- ☐ Divorce
- ☐ Pending Marriage
- ☐ Financial Problems
- ☐ Pregnancy
- ☐ Career Change
- ☐ Fired from Work
- ☐ Marital Reconciliation
- ☐ Taking on Debt
- ☐ Death of a Family Member
- ☐ New Person Joins Family
- ☐ Marital Separation
- ☐ 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
   - Temples
   - 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

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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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)

<table>
<thead>
<tr>
<th>Bite Splint</th>
<th>Medication</th>
<th>Physical Therapy</th>
<th>Occulusal Adjustment</th>
<th>Orthodontics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other ☐</td>
<td>(Please explain): ____________________________</td>
<td></td>
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</tbody>
</table>

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 ☐

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED

<table>
<thead>
<tr>
<th>Degree of current TMD pain:</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of TMD pain:</td>
<td>Daily</td>
<td>Weekly</td>
<td>Monthly</td>
<td>Semi-Annually</td>
<td>After Eating</td>
<td></td>
<td></td>
<td></td>
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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 its 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? __________________________

<table>
<thead>
<tr>
<th>Right</th>
<th>Clicking/Popping</th>
<th>Grinding</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left</td>
<td>Clicking/Popping</td>
<td>Grinding</td>
<td>Other</td>
</tr>
</tbody>
</table>

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? __________________________