



American Association of
Orthodontists

History Form for Patient with Temporomandibular Disorder

Date _____

Name _____ Birth date _____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems

	Left	Right	Comments
Joint clicking or popping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Grating noises	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Jaw locks open	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Jaw locks closed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Limited jaw opening	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Jaw does not open smoothly	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Soreness of jaw joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Soreness of face muscles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Teeth Problems

		When?	Comments
Teeth grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Teeth clenching	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Soreness of one or more teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where? _____	_____
Looseness of one or more teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Where? _____	_____

Head and Facial Pain

	Left	Right	(least)	Degree of Pain										(most)
Migraine-type headache	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10	
Cluster headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10	
Sinus headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10	
Headaches in back of head	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10	
Hair and/or scalp painful to touch	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	0	1	2	3	4	5	6	7	8	9	10	

Ear or Balance Problems

		Comments
Pain in ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
ringing or buzzing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Clogged or stuffy ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diminished hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Dizziness or vertigo	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Poor sense of balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

SYMPTOMS *continued* Please mark each symptom that applies.

Throat Problems

- Swallowing difficulty Yes No
- Throat tightness Yes No
- Throat soreness Yes No
- Laryngitis Yes No
- Voice fluctuations Yes No
- Throat congestion Yes No
- Frequent cough Yes No
- Frequent throat clearing Yes No
- Excessive salivation Yes No
- Tongue pain Yes No
- Pain in roof of mouth Yes No

Comments

Neck and/or Shoulder Pain

- Neck/shoulder/back pain Yes No
- Neck/shoulder/back reduced mobility Yes No
- Frequent neck muscle fatigue Yes No
- Arm or finger tingling, numbness, pain Yes No

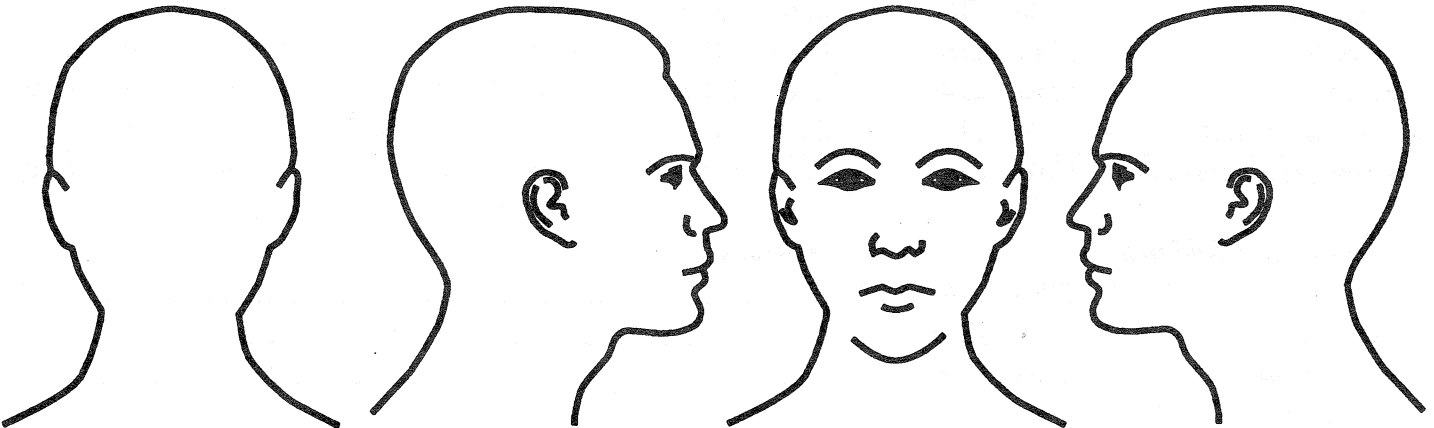
Comments

Eye Problems

- Pain around or behind eyes Yes No
- Bloodshot eyes Yes No
- Blurred vision Yes No
- Pressure behind eyes Yes No
- Light sensitivity Yes No
- Watering of eyes Yes No
- Drooping of eyelids Yes No

Comments

On the figures below, please place an X where you have pain. Circle the X where the pain is most severe.



PATIENT HEALTH INFORMATION

Do you have any recent or childhood history of trauma to the head or face (such as falls, auto accident, blows to the head or face, sports injury)?

If yes, please describe: _____

Do you have a frequent activity that causes you to hold your head or neck in an imbalanced position (such as playing instrument, keyboarding, holding phone, etc)? If yes, please describe: _____

Have you been treated for a TMD problem before? If so, when? _____

By whom? _____

Was the problem the same or different than your current problem? _____

What treatment did you have? _____

Do you think the treatment was successful? _____

What would you like your treatment here to achieve? _____

UPDATES

Updates _____

Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____

Updates _____

Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____

Updates _____

Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____

Updates _____

Patient Signature _____ Date _____
Dental Staff Signature _____ Date _____