TMJ Patient History Form

Genecov Orthodontics of Dallas
Healthy smiles. Beautiful faces.
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1. Name: _____ Birthday: _____
   First MI Last

   Address: _____

   City: _____ State: _____ ZIP: _____

   Phone: (_____) _____ Age: _____ Sex: _____ Referring doctor: _____

2. In your own words, describe why you are here: _____

   _____

   _____

3. 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 any medication you are taking: _____

4. Dentist's name: _____

   Date of last dental appointment: _____

   Treatment prescribed: _____

5. Do you have any problems with your jaw? ❑ Yes ❑ No

   If yes, please describe: _____

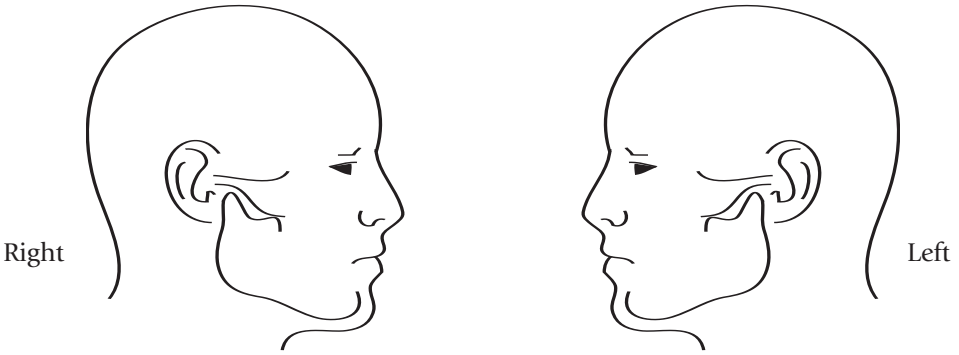
   How long have you had these problems? _____

6. Have you received treatment for jaw problems? ❑ Yes ❑ No

   Who directed this treatment? _____

What was the treatment? (indicate below)	Yes	No	Results: Good	Fair	Poor
Bite splint	❑	❑	❑	❑	❑
Medication	❑	❑	❑	❑	❑
Physical therapy	❑	❑	❑	❑	❑
Occlusal adjustment	❑	❑	❑	❑	❑
Orthodontics	❑	❑	❑	❑	❑
Counseling	❑	❑	❑	❑	❑
Surgery	❑	❑	❑	❑	❑
Other _____			❑	❑	❑

7. On the figurew below, mark an X where you have pain and circle the X where pain is most severe.



When do you have this pain? _____

8. Do you do anything now to relieve your pain? ❑ Yes ❑ No

If yes, what? _____

9. Are you aware of anything that makes your pain worse? ❑ Yes ❑ No

If yes, what? _____

10. Do your jaw joints make noises? ❑ Yes ❑ No

Right jaw ❑ Clicking ❑ Popping ❑ Grinding ❑ Other _____

Left jaw ❑ Clicking ❑ Popping ❑ Grinding ❑ Other _____

11. Has your jaw ever locked open? ❑ Yes ❑ No

If yes, when did this first occur? _____

How often has this occurred? _____

12. Has your jaw ever locked closed or partly closed? ❑ Yes ❑ No

If yes, when did this first occur? _____

How often has this occurred? _____

13. Have you ever injured your jaws? ❑ Yes ❑ No

If yes, when? _____

Please describe the injury: _____

_____

14. Do you consider yourself to be under more stress than most people? ❑ Yes ❑ No

15. Please provide any additional information you feel may be helpful in the diagnosis or treatment of your condition:

_____

_____

_____