Renew Oral & Facial Surgical Centre

TMJ EVALUATION

I. PERSONAL INFORMATION

Date _____

Name _____

Address _____

Age _____ Occupation _____

Home Phone _____ Work Phone _____

Insurance Carrier: Medical _____
Dental _____

I was referred by _____

II. HISTORY

A. The history of the problem is: _____
_____
_____
_____
_____
_____
_____

B. Your present problem is: _____
_____
_____
_____
_____
_____
_____

C. Was the first appearance of the problem associated with:

_____ Trauma
_____ Yawning
_____ Dental Care
_____ Stress/Tension

Please describe: _____
_____
_____
_____
_____
_____
_____

D. Please list all other physicians, dentists, physical therapists, chiropractors, psychologists, etc. who have treated you for this problem. Please give approximate dates and the care received (for example: bite splints, medication, physical therapy, counseling, etc.).

_____
_____
_____
_____
_____
_____

E. Past medical history (please give approximate dates).

Illness _____
Hospitalizations _____
Operations _____
Allergies _____
List all medicines you are now taking _____
_____

Do you have the following:	Arthritis	Yes ____	No ____
	Nervous stomach or ulcers	Yes ____	No ____
	Low back pain	Yes ____	No ____
	Frequent oral ulcers	Yes ____	No ____

III. SYMPTOMS

Do you have:

A. Headaches Yes _____ No _____

1. Where are they? _____
   _____
2. How long do they last? _____
   _____
3. How often do they occur? _____
   _____
4. Are the headaches associated with:
   _____ Nausea
   _____ Visual Changes
   _____ Confusion
   _____ Facial paralysis
   _____ Facial sweating/tearing
   _____ Burning

B. Neck or shoulder pain Yes _____ No _____

1. Where is it? _____
   _____
2. How often does it occur? _____
   _____

C. Jaw Pain Yes _____ No _____

1. Where is it? _____
   _____
2. How often does it occur? _____
   _____
3. What makes it better? _____
   _____
4. What makes it worse? _____
   _____

D. Ear Pain? Yes _____ No _____

1. Where is it? _____
   _____
2. How often does it occur? _____
   _____

3. Do you have:
    a. Ringing in your ears? Yes _____ No _____
    Which side? _____
    How often? _____
    b. Hearing difficulty? Yes _____ No _____
    Which side? _____
    How often? _____
    c. Itching of the ears? Yes _____ No _____
    Which side? _____
    How often? _____
    d. Clogged/stuffy sensation in the ears? Yes _____ No _____
    Which side? _____
    How often? _____
    e. Dizziness? Yes _____ No _____
    Which side? _____
    How often? _____
    f. Drainage? Yes _____ No _____
    Which side? _____
    How often? _____

E. Do you jaws make noise? Yes _____ No _____
1. Which side? _____
2. How often? _____
3. What makes it better? _____
_____
4. What makes it worse? _____
_____
5. When did you first notice these jaw sounds? _____
_____
6. Has the noise changed its character? _____
_____

F. Have your jaws ever locked so that you could not:
Open? Yes _____ No _____
Close? Yes _____ No _____

How often does this occur? _____
_____
Has this frequency increased recently? _____
_____
How do you correct the locking? _____
_____

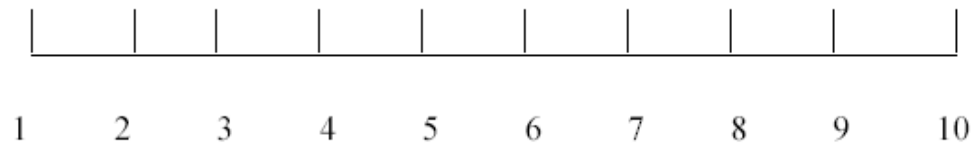
G. Do you clench or grind your teeth:
At night? Yes _____ No _____
During the Day? Yes _____ No _____

H. What will make your symptoms better? _____
_____
What will make your symptoms worse? _____
_____

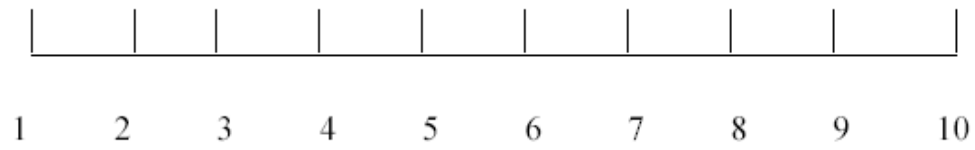
I. Are your symptoms worse in the morning or are they worse later in the day? ___
_____
_____

J. Are your jaws sore or stiff in the morning? Yes _____ No _____
K. Do you have sore or sensitive teeth? Yes _____ No _____
L. Do you have trouble getting to sleep? Yes _____ No _____
M. Do you sleep well? Yes _____ No _____
N. Do you dream? Yes _____ No _____
O. Do you consider yourself a tense person? Yes _____ No _____
P. Has your life been more stressful recently? Yes _____ No _____
Q. Are you presently seeing a psychologist/psychiatrist? Yes _____ No _____
R. On the scale of 1-10 below mark where your pain falls at each of the following times:

Most of the time – mark with a line (/)
At its worst – mark with a circle (o)
At its best or least – mark with an (x)



S. The pain is having this effect on my life:



T. On the figures below, please circle where your pain is: