Oral and Maxillofacial Surgery Associates, P.A.

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TEMPOROMANDIBULAR JOINT EVALUATION
CONFIDENTIAL INFORMATION

DATE:______________________________

PATIENT NAME: ____

NATURE OF PROBLEM:
____
____

DATE OF ONSET: ____________

DID SYMPTOMS FOLLOW ANY PHYSICAL INJURY OR EMOTIONAL OCCURRENCE? PLEASE DESCRIBE IN DETAIL:
____
____
____

CHECK SPECIALIST(S) YOU HAVE CONSULTED FOR THIS PROBLEM:

( ) General Physician	( ) Clinic	( ) Dentist
( ) Chiropractor	( ) Psychiatrist	( ) Oral Surgeon
( ) ENT	( ) Psychologist	( ) Orthodontist
( ) Neurologist	( ) Physical Therapist	( ) Periodontist

LIST MEDICATIONS YOU ARE CURRENTLY TAKING FOR THIS CONDITION: ____

LIST TREATMENT YOU HAVE RECEIVED FOR THIS CONDITION: ________
____

WHICH TREATMENT HAS PROVEN MOST SUCCESSFUL TO DATE:
____
____

PLEASE DESCRIBE WHAT AGGRAVATES YOUR CONDITION:
____
____

WHAT EFFECTIVELY RELIEVES YOUR PAIN?

____

____

DOES YOUR PAIN INTERFERE WITH YOUR DAILY ROUTINE? IF YES, PLEASE DESCRIBE:

____

____

ON A SCALE OF 1 TO 10 (10 being greatest), PLEASE INDICATE THE NUMBER THAT BEST DESCRIBES THE SEVERITY OF YOUR PAIN.

____

SYMPTOMS:

Y	**N**	**TENSION HEADACHES**
Y	**N**	**DIAGNOSED MIGRAINE HEADACHES**
Y	**N**	**DEPRESSION**
Y	**N**	**DIFFICULTY IN SWALLOWING OR CHEWING NORMAL DIET**
Y	**N**	**PAINFUL MOUTH**
Y	**N**	**SORENESS OF FACE OR NECK AREAS**
Y	**N**	**STIFF NECK**
Y	**N**	**GRINDING OF TEETH**
Y	**N**	**CLENCHING OF TEETH**
Y	**N**	**GRINDING OR CLENCHING WHILE SLEEPING**
Y	**N**	**POPPING OR GRINDING SOUNDS IN THE JAW AREA**
Y	**N**	**DIFFICULTY OPENING MOUTH WIDELY**
Y	**N**	**DIFFICULTY IN CLOSING YOUR MOUTH NORMALLY**
Y	**N**	**CHANGE IN YOUR OCCLUSION (BITE)**
Y	**N**	**STIFFNESS OF JAW UPON AWAKENING**
Y	**N**	**SORE TEETH UPON AWAKENING**
Y	**N**	**SLEEP DISTURBANCES OR PROBLEMS**
Y	**N**	**ARTHRITIS OR PROBLEMS WITH OTHER JOINTS**
Y	**N**	**HISTORY OF ORTHODONTIC TREATMENT**
Y	**N**	**HISTORY OF TMJ INJURY, TREATMENT OR SURGERY**

SIGNATURE: ____
(PATIENT/ PARENT / GUARDIAN)

DATE: ________________