ALAMO MAXILLOFACIAL
SURGICAL ASSOCIATES, PA

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).

Illnesses _____

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 _____

How often? _____

f: Drainage? Yes _____ No _____

Which side? _____

How often? _____

E. Do your 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? Yes _____ No _____

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 you 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 has 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:

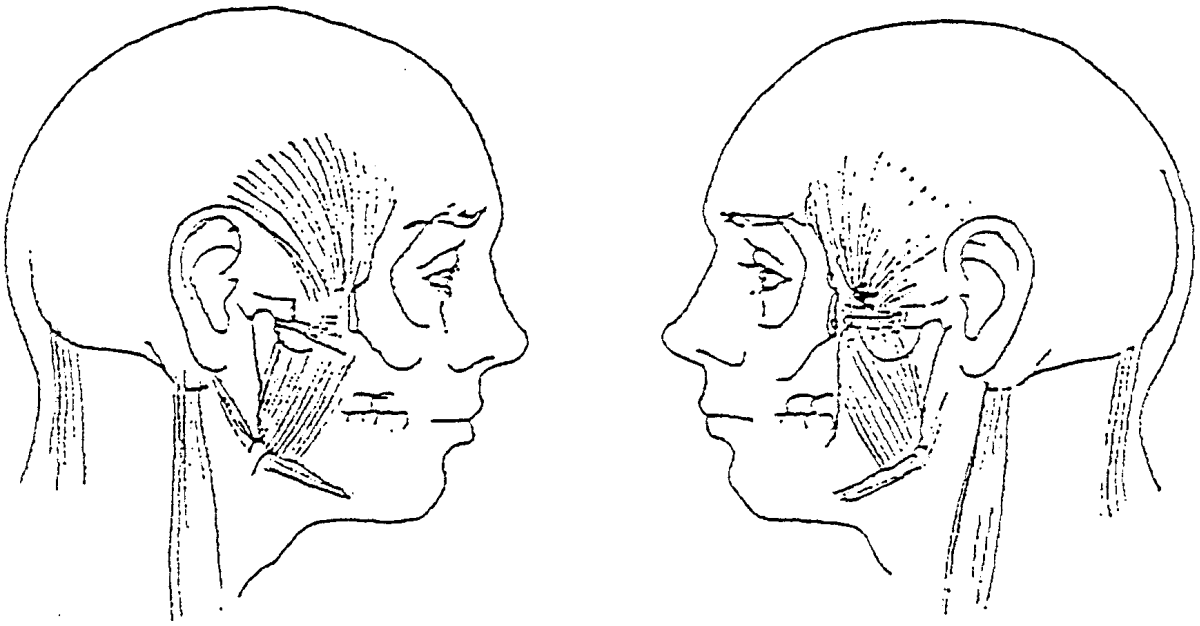
Most of the time – mark with a line (/).

At its worst – mark with a circle (o).

At its best or least – mark with an (X).

1 2 3 4 5 6 7 8 9 10

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

1 2 3 4 5 6 7 8 9 10

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