

# TMJ Patient 's Report

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is your chief complaint?

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If you could make a difference in your condition, what would you like to have improved?  
List in order of importance (1-10, 1 being the most important)

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Who referred you to this office?

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

PLEASE LIST PREVIOUS AND PRESENT DENTAL HEALTH CARE PROVIDERS (please make sure names and addresses are complete with street numbers and zip codes).

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis and treatment: \_\_\_\_\_

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis and treatment: \_\_\_\_\_

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis and treatment: \_\_\_\_\_

**Trauma History:** In an effort to provide you with the best care possible, it is very important that we have as complete and as detailed a history of injuries you have sustained, and treatments received. In addition, there are certain lifestyle factors which may interfere with treatment. Therefore, we will be interested in aspects of your life which you may, at first glance, think unrelated to the problems which prompted your coming to T.M.J. Dental Consultants, Inc.

Have you ever been involved in Accidents in the past in which your head snapped, such as in whiplash auto accidents? \_\_\_\_\_  
If so, please list every accident of this type below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# History

1. Would you say your health in general is  
Excellent Very good Good Fair Poor
2. Would you say your oral health in general is  
Excellent Very good Good Fair Poor
3. Have you had pain in the face, jaw, temple, in front of the ear, or in the ear in the past?  
Yes No
4. a. How many years ago did your facial pain begin for the first time?  
\_\_\_\_\_
- b. How many months ago did your facial pain begin for the first time?  
\_\_\_\_\_
- c. Is your facial pain  
Persistent Recurrent One time
5. Have you ever gone to a  
Physician Dentist Chiropractor Other  
health professional for facial aches or pains? If so, when?  
\_\_\_\_\_
6. How would you rate your facial pain on a 0-10 scale at the present time, where 0 is "No pain" and 10 is "Pain as bad as it could be"?  
0 1 2 3 4 5 6 7 8 9 10
7. In the past 6 months, how intense was your worst pain, rated on a 0-10 scale as described in #6?  
0 1 2 3 4 5 6 7 8 9 10
8. In the past 6 months, or the average, how intense was your pain rated on a 0-10 scale?  
0 1 2 3 4 5 6 7 8 9 10
9. About how many days in the past 6 months have you been kept from your usual activities (work, school, housework, etc.) because of pain?  
\_\_\_\_\_
10. In the past 6 months, how much has your facial pain interfered with your daily activities rated on a 0-10 scale where 0 is "No interference" and 10 is "Unable to carry on with any other activities"?  
0 1 2 3 4 5 6 7 8 9 10
11. In the past 6 months how much has facial pain changed your ability to take part in recreational, social and family activities, on a 0-10 scale?  
0 1 2 3 4 5 6 7 8 9 10
12. In the past 6 months, how much has facial pain changed your ability to work (including housework) where 0 is "No change" and 10 is "extreme change"?  
0 1 2 3 4 5 6 7 8 9 10
13. a. Have you ever had your jaw lock or catch so that it won't open all the way?  
Yes No
- b. Was this limitation in jaw opening severe enough to interfere with your ability to eat?  
Yes No
14. a. Does your jaw click or pop when you open or close your mouth when chewing or otherwise?  
Yes No
- b. Does your jaw make a grating noise when it opens and closes or when chewing?  
Yes No
- c. Have you been told, or do you notice, that you grind your teeth or clench your jaw while sleeping at night?  
Yes No
- d. During the day, do you grind your teeth or clench your jaw?  
Yes No
- e. Does your jaw ache or feel stiff when you wake up in the morning?  
Yes No

# History

14. f. Do you have noises or ringing in your ears?

Yes  No

g. Does your bite feel uncomfortable or unusual?

Yes  No

15. a. Do you have rheumatoid arthritis, lupus, or any other systematic arthritic disease?

Yes  No

b. Do you know of anyone in your family who has had any of these diseases?

Yes  No

If yes, which?

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c. Have you had or do you have any swollen or painful joints other than the joints close to your ears (TMJ)?

Yes  No

d. If yes, is this a persistent pain that you have had for at least one year?

Yes  No

16. a. Have you had a recent injury to your face or jaw?

Yes  No

b. Did you have jaw pain before the injury?

Yes  No

17. During the last 6 months, have you had a problem with headaches or migraines?

Yes  No

18. Please check any activity below which your present jaw problem prevents or limits you from doing.

Chewing

Drinking

Exercising

Eating hard foods

Eating soft foods

Smiling/Laughing

Sexual activity

Brushing your teeth

Cleaning/Washing your face

Yawning

Swallowing

Talking

Having your usual face appearance

Have you received a blow to the face or jaw? \_\_\_\_\_ if so, please list every accident or incident of this type.

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Have you been involved in any type of accident, fall, injury or surgery? \_\_\_\_\_ if so, please list every incident.

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Please list the treatments you have received for accidents or incidents listed.

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Please list previous treatments for the condition which prompted you to come to this center.

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Are you presently in litigation related to head, neck, back and/or jaw symptoms?

Yes \_\_\_\_ No \_\_\_\_

Partial disability \_\_\_\_\_ Total disability \_\_\_\_\_

If yes, what is the nature of your disability?

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Date you stopped working?

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When has your physician indicated that you can return to work?

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# Craneomandibular Examination

Chief Complaint: \_\_\_\_\_

Duration of the problem: \_\_\_\_\_

Problem is most severe:  Morning  Afternoon  Evening  Sleeping  Eating  No pattern

Present Medications: \_\_\_\_\_

Symptoms					Left	Right
Face Pain	Forehead	Cheeks	Nose	Around the eyes		
Head Pain	Front	Back	Side	Top		
Ear	Pain	Stuffy	ringing	Loss of Hearing		
Eye	Pain	Redness	Pressure	Loss of Focus		
Arm/Fingers	Pain	Tingling	Numbness	Weakness		
Neck	Pain	Tightness	Stiffness	Noise on Movement		
Joint	Pain	Clicking	Grinding	Locking Open/Close		
Upper Back	Pain	Stiffness	Spasms	Noise on Movement		
Lower Back	Pain	Stiffness	Spasms	Noise on Movement		
Throat Sore	Pain	Tightness	Dryness	Difficult to Swallow		
Dental Problems: <input type="radio"/> Pain <input type="radio"/> Swelling Bite Problems: _____ Other: _____						

Pain Description (Please circle)

Sharp      Stabbing      Dull      Deep      Throbbing      Burning      Prickling  
 Mild      Moderate      Severe      Agony      Continuous      Intermittent      Recurrent  
 Localized      Generalized      Radiating      Migrating

What is your worst symptom?

\_\_\_\_\_

What makes it feel better?

\_\_\_\_\_

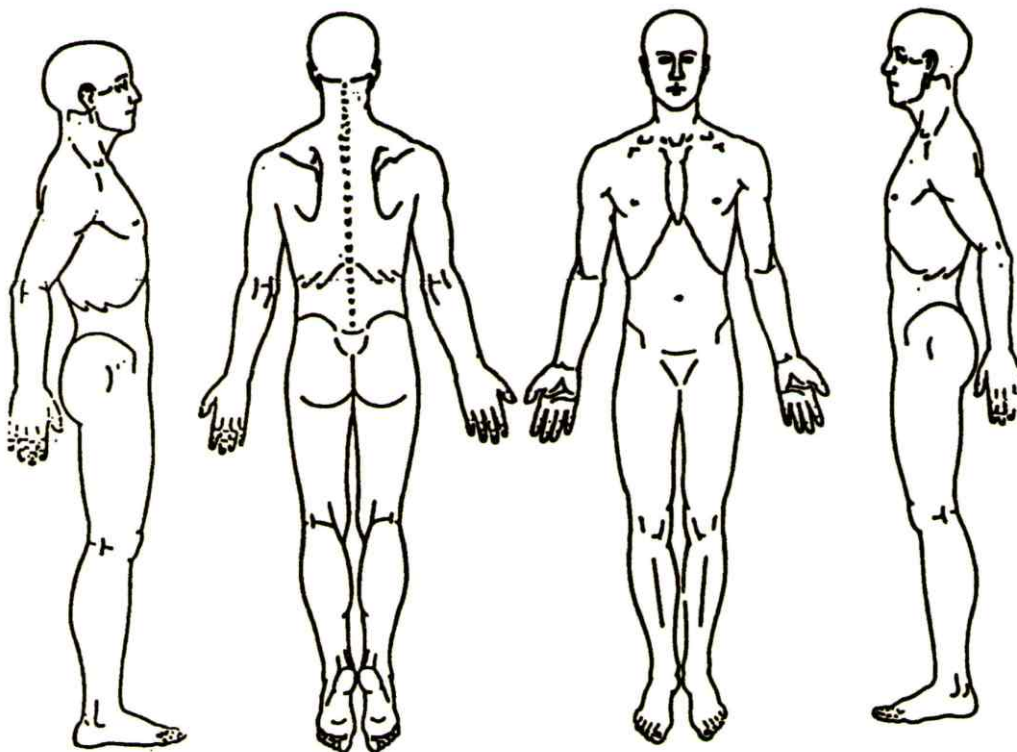
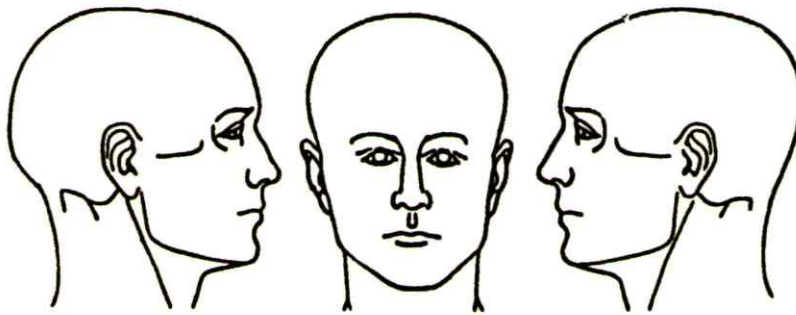
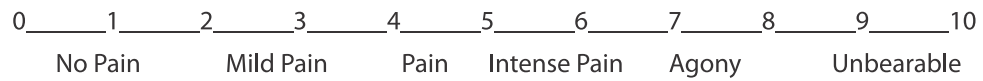
What makes it worse?

\_\_\_\_\_

# Pain areas

Please indicate area(s) of pain and discomfort on the diagrams below. On your WORST day, also indicate the type of pain: B for burning, T for throbbing, S for sharp, D for dull.

In addition please assess the pain on this 10 point scale in each area you feel pain





## Medication History

• To be reviewed with the patient, include hormonal, B.P., etc.

Name of medication	Dosage	How taken	How long on it	Purpose of Meds	Prescribed by Doctor/Specialty

Family History of TMJ Disorders and Connective Tissue Disorders (Review and list from history)

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## Habit History

Gum Chewing       Nail Biting       Musical Instrument

Clenching     Day     Night      Bruxism     Day     Night

Type of Exercise: \_\_\_\_\_ Frequency: \_\_\_\_\_

## Home/Work Daily (habits and history)

Types of Daily Activities:

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Usual posture and position at work or at home:

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# T.M.J. Consent

We are dedicated to the diagnosis and treatment of Temporomandibular Disorders, Dental Occlusion and Orofacial Pain. These disorders very often mimic medical signs and symptoms that sometimes can be very hard to identify and diagnose.

Most of the time, these symptoms are subjective and the improvement of these conditions can only be recognized by you. Many of these signs and symptoms have to be treated in a multidisciplinary way to have better chances of getting you better. The decision of getting and accepting to follow our suggestions depends only on you, and your commitment to your own treatment.

Dr. Alvaro Ordonez is one of the very few doctors in South Florida trained at a university residency full time program in the area of TMJ and Facial Pain. We have a high success rate treatment, but there is always a possibility of not getting you better. There are so many variables involved in your treatment, including your own compliance.

Regular adjustments to the splints are necessary for the success of TMJ treatment. These splints can break due to mishandling or neglect in which case you are responsible for the replacement cost.

**The fees involved in the consultation, diagnosis and treatment processes are non refundable.**

By signing below you refuse your right to ask for money back, to stop payment of a check, to dispute credit card payments, and to accept any fees related to court charges and attorney fees.

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Patient / Guardian Signature

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Date

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Patient's Name