Levon Nikoyan DDS ⟷ Stanley E. Matthews DDS
Forward Oral and Maxillofacial Surgery



248-62 Jericho Turnpike Bellerose Village NY
T: 516-775-2222 F:516-900-2718

TMJ Patient History Form

1. Name _____
   Referred by _____
2. In your own words, explain 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? _____

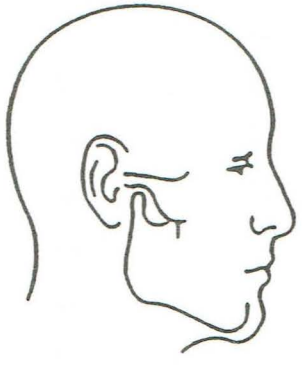
What was the treatment? (Please indicate below)	Yes	No	RESULTS Good	Fair	Poor
Bite splint	❑	❑	❑	❑	❑
Medication	❑	❑	❑	❑	❑
Physical therapy	❑	❑	❑	❑	❑
Occlusal adjustment	❑	❑	❑	❑	❑
Orthodontics	❑	❑	❑	❑	❑
Counseling	❑	❑	❑	❑	❑
Surgery	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

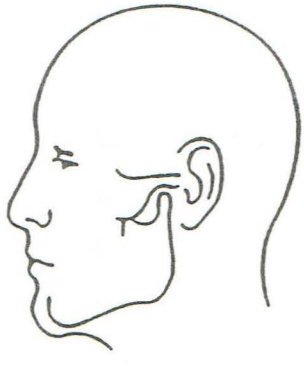
7. Do you now have any of the following symptoms?

		Locations	How long?
Headaches	_____	_____	_____
Neck Pain	_____	_____	_____
Jaw joint pain	_____	_____	_____
Ear: Pain	_____	_____	_____
Dizziness	_____	_____	_____
Stuffiness	_____	_____	_____
Ringing or buzzing	_____	_____	_____
Facial pain	_____	_____	_____
Pain behind the eyes	_____	_____	_____

8. Is the pain
   - Constant? _____
   - Burning? _____ _____
   - Stabbing? _____
   - Aching? _____
   - Worse in the afternoon or evening? _____
   - Worse in the morning on awaking? _____
   - Referred to other areas of the face, head, or neck? _____
9. Does it hurt
   - To eat or chew? _____
   - To talk? _____
   - To open wide? _____
   - To smile, kiss, Etc.? _____
   - To swallow? _____
10. Does the pain interfere with your:
    - Occupation? _____
    - Social life? _____
    - Family life? _____
    - Sleep? _____
11. On the figures below: Mark an X where you have pain
    Circle the X where pain is most severe

RIGHT





LEFT

12. Place an X along the lines below to show how your pain is today.

Absent _____ Most intense

Not unpleasant _____ Most unpleasant

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

Right: Clicking ❑ Popping ❑ Grinding ❑ Other ❑

Left: Clicking ❑ Popping ❑ Grinding ❑ Other ❑

14. Has your jaw ever "locked"? _____ How often? _____

Open _____

Closed _____

Was the locking associated with any particular event? _____

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

When _____

Please describe the injury _____

16. Have you ever had orthodontia (braces)? _____

17. Have you had your wisdom teeth removed? _____

18. Have you ever had long dental appointment or general anesthesia? _____

19. Do you ever clench or grind your teeth? _____

During the day? _____ At night? _____

If so, do you associate this with any particular cause? _____

20. Is your pain worse in the

Morning _____ Afternoon _____ Evening _____ Night _____

21. Are your jaw muscles often sore and stiff when you awaken in the morning? _____

22. Are your teeth ever sore or sensitive to hot, cold or chewing? _____

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

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

Doctors use only

Maximal intercuspal opening

--------- mm with pain

--------- mm without pain

Protrusion

---------mm

Lateral Excursion

Left --------- mm

Right -------- mm

Deviation on opening Left -------- Right --------

Masticatory muscle tenderness

Right -------- Left --------

Occlusion Angle Class --------

Panorex _____

_____

Dental Exam _____

_____

_____

_____

_____