TMJ Patient´s Report

Patient's Name: _____ Date: _____

What is you chief complaint?

If you could make a diference 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 efort 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. I 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 irst 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 stif 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?

_____

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.

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

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

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

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?

Date you stopped working?

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

Please give us a detailed chronological history of the condition you have come to be examined for.

For patient's use	For doctor's use

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	Stufy	Ringing	Loss of Hearing		
Eye	Pain	Redness	Pressure	Loss of Focus		
Arm/Fingers	Pain	Tingling	Numbness	Weakness		
Neck	Pain	Tightness	Stifness	Noise on Movement		
Joint	Pain	Clicking	Grinding	Locking Open/Close		
Upper Back	Pain	Stifness	Spasms	Noise on Movement		
Lower Back	Pain	Stifness	Spasms	Noise on Movement		
Throat Sore	Pain	Tightness	Dryness	Dificult to Swallow		

Dental Problems: ◯ Pain ◯ 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?

_____

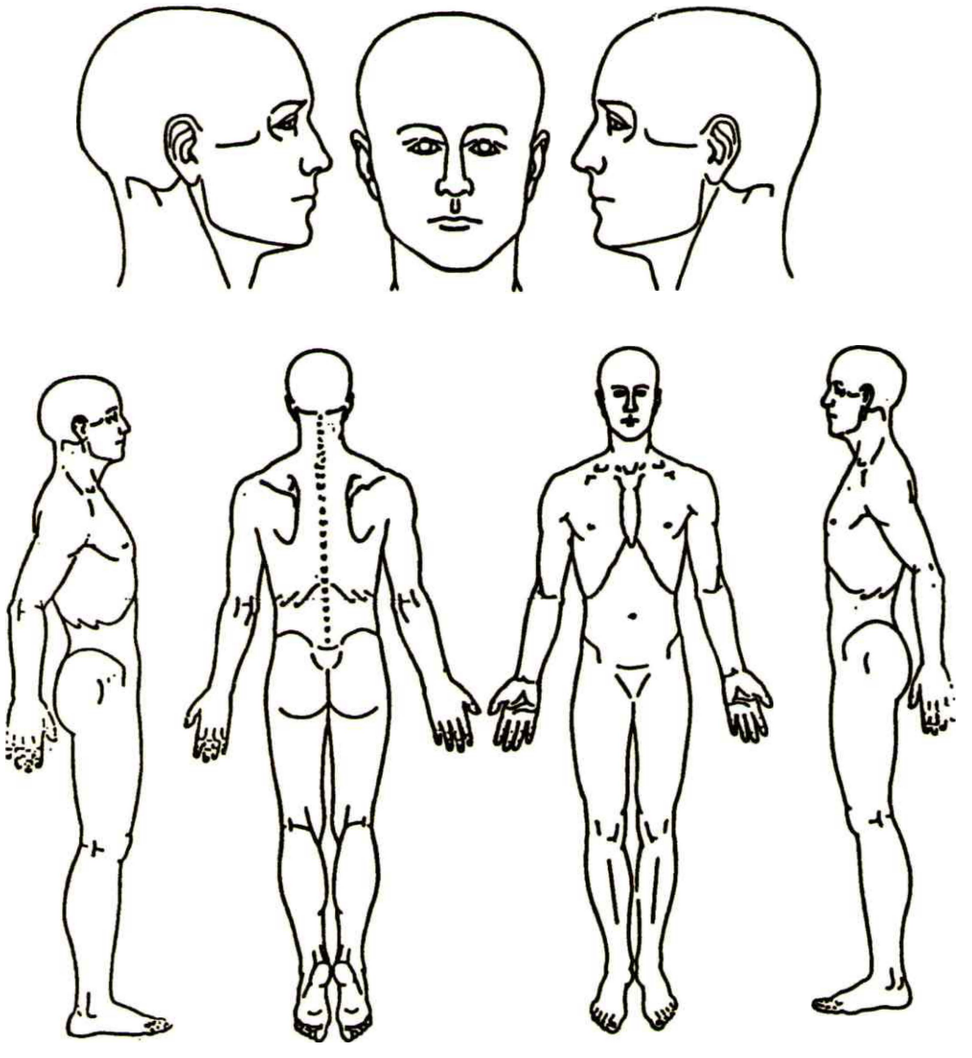
Pain areas

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

0_____ _____2_____3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8_____9 ___ 10

No Pain Mild Pain Pain Intense Pain Agony Unbearable



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)

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:

Usual posture and position at work or at home:

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.

_____ _____

Patient / Guardian Signature Date

_____

Patient's Name

Discomfort Scale

Patient's name: _____ Date: _____

Think of each scale below as a thermometer. For each part of the body indicated report the average of discomfort for the last seven days. Place an "X" on the square line marked "**L**" to report discomfort on your left side, and an "X" on the bottom square line marked "**R**" to report discomfort on your right side.

		None	Begining		Mild		Moderate		Severe		Intolerable	
		0	1	2	3	4	5	6	7	8	9	10
EARACHE	L											
	R											
EAR STUFFINESS	L											
	R											
TM JOINT PAIN	L											
	R											
TM JOINT CLICKING	L											
	R											
HEADACHES	L											
	R											
FACE PAIN	L											
	R											
ARM Pain / Tingling / Numbness	L											
	R											
NECK Pain / Stiffness	L											
	R											
UPPER BACK Pain / Stiffness	L											
	R											
LOWER BACK Pain / Stiffness	L											
	R											

Describe changes since last visit: _____

_____

_____

At what time were your symptoms worse? _____

_____

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