

Lakewood
 1840 So. Wadsworth
 Lakewood, CO 80232
 (303) 988-0844
 bobakortho.com



Aurora
 14251 E 6th Ave., Aurora, CO 80011
 (303) 988-0844
 Thornton
 550 E. Thornton Pkwy., Thornton, CO 80229
 (303) 988-0844



CONFIDENTIAL



History Form for Patient with Temporomandibular Disorder

Date _____

Name _____ Birth date _____

What problems do you have with your jaw joints, jaw muscles and/or teeth? _____

When did these problems start? _____

What do you think caused these problems? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems

	Left		Right		Comments
Joint clicking or popping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Grating noises	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Jaw locks open	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Jaw locks closed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Limited jaw opening	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Jaw does not open smoothly	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Soreness of jaw joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Soreness of face muscles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Teeth Problems

Teeth grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Teeth clenching	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Soreness of one or more teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Looseness of one or more teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____

Head and Facial Pain

	Left		Right		(least) Degree of Pain (most)										
Migraine type headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Cluster headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Sinus headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Headaches in back of head	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Hair and/or scalp painful to touch	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

Ear or Balance Problems

Pain in ear	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
ringing or buzzing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Clogged or stuffy ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Diminished hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Dizziness or vertigo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____
Poor sense of balance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments _____