E LINE ORTHODONTICS, PLLC.
YOON H. CHANG DDS MS

Temporomandibular Disorder Medical History Form

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

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

When did the problems start? _____ What do you think caused the symptoms? _____

SYMPTOMS Please mark each symptom that applies.

Jaw Joint Problems

Joint clicking or popping ..... Yes No Which side? _____ Grating noises ..... Yes No Which side? _____

Soreness of jaw joints ..... Yes No Which side? _____ Soreness of face muscles ..... Yes No Which side? _____

Jaw locks open ..... Yes No Jaw locks closed ..... Yes No Limited jaw ..... Yes No

Jaw does not open smoothly ... Yes No Other jaw joint problems: _____

Teeth Problems

Teeth grinding ..... Yes No Teeth clenching ..... Yes No Teeth soreness ..... Yes No

Loose teeth ..... Yes No Other teeth problems: _____

Head and Facial Pain

Migraine type headache ..... Yes No Degree of pain _____ Cluster headaches ..... Yes No Degree of pain _____

Sinus headaches ..... Yes No Degree of pain _____ Headaches in back of head ..... Yes No Degree of pain _____

Scalp painful to touch ..... Yes No Degree of pain _____ Other head/facial pain: _____

Ear and Balance Problems

Pain in ear ..... Yes No Which side? _____ Ringing or buzzing ..... Yes No Which side? _____

Clogged or stuffy ears ..... Yes No Which side? _____ Diminished hearing ..... Yes No Which side? _____

Dizziness or vertigo ..... Yes No Poor sense of balance ..... Yes No Other ear/balance problems: _____

Throat Problems

Swallowing difficulty ..... Yes No Throat tightness ..... Yes No Throat soreness ..... Yes No

Laryngitis ..... Yes No Voice fluctuations ..... Yes No Throat congestion ..... Yes No

Frequent cough ..... Yes No Frequent throat clearing ..... Yes No Excessive salivation ..... Yes No

Tongue/roof of mouth pain ... Yes No Other throat problems: _____

Neck and/or Shoulder Pain

Neck/shoulder/back pain ..... Yes No Reduced mobility ..... Yes No Neck muscle fatigue ..... Yes No

Arm or finger tingling, numbness, pain ..... Yes No Other neck/shoulder problems: _____

Eye Problems

Pain around or behind eyes ... Yes No Bloodshot eyes ..... Yes No Blurred vision ..... Yes No

Pressure behind eyes ..... Yes No Light sensitivity ..... Yes No Watering of eyes ..... Yes No

Drooping of eyelids ..... Yes No Other eye problems: _____

On the figures below, mark an X where you have pain. Circle the X where the pain is most severe.