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HEAD-NECK & TMJ HISTORY

Please help us understand your problem by checking the following information; please be specific *(Circle the words right, left, yes, or no.):*

Disc History:

Have you heard popping sounds in your ear(s)?	*right / left* _____
Has the popping stopped?	*right / left*_____
Has the size of your jaw opening decreased?	*right / left*_____
Do you hear clicking sounds in your ear(s)?	*right / left* _____
Do you hear grinding sounds in your ear(s)?	*right / left* _____
Do you have pain in your ear(s)?	*right / left* _____

Muscle History:

Is your jaw opening limited?	*yes / no*_____
Is your opening limitation most in the morning?	*yes / no*_____
Do you wake up with facial pain?	*yes / no* _____
Do you have pain below your ear(s)?	*yes / no* _____
Do you have pain in your temples?	*yes / no* _____
Do you clench or grind your teeth?	*yes / no* _____
Do you have lower neck aches or backaches?	*yes / no* _____
Are you in an emotional period of your life?	*yes / no* _____

Joint Change History:

Has your bite changed?	*yes / no* _____
Has your chin moved backwards?	*yes / no* _____
Do your teeth hit unevenly?	*yes / no* _____
Have you had jaw surgery or orthodontic treatment?	*yes / no* _____
Do you clench or grind your teeth?	*yes / no* _____
Have you heard popping sounds in your ear(s)?	*yes / no* _____
Have you had an injury to your face, head, neck or jaw?	*yes / no* _____
Are you a female?	*yes / no* _____
Are you between 12 and 17 years old?	*yes / no* _____
Are your arms, legs, feet, hands or finger joints painful swollen or stiff?	*yes / no* _____
Are you or have you taken corticosteroids?	*yes / no* _____
Do you or have you had hyperparathyroidism?	*yes / no* _____

Obstructive Sleep Apnea History:

Do you fall asleep during the day?	*yes / no* _____
Have you fallen asleep while driving?	*yes / no* _____
Do you have disrupted sleep?	*yes / no* _____
Do you urinate frequently during the night?	*yes / no* _____
Do you snore heavily at night?	*yes / no* _____
Do you talk in your sleep?	*yes / no* _____
Do you suffer from daytime fatigue?	*yes / no* _____
Do you experience daytime sleepiness?	*yes / no* _____
Have you had a recent weight gain?	*yes / no* _____

Do you have high blood pressure? *yes / no*_____
Do you take blood pressure medication? *yes / no* _____
Do you have an irregular heartbeat? *yes / no* _____
Do you suffer from depression? *yes / no* _____
Do you have headaches when you wake up? *yes / no* _____
Does your spouse see you stop breathing during sleep? *yes / no* _____
Do you drink alcoholic beverages? *yes / no* _____
Do you take sedative type medication? *yes / no* _____

Chronology:

When did you first notice the above symptoms? *Date:*_____

Have the above symptoms increased with time? *yes / no*_____
Do you attribute the symptoms to one incident? *yes / no*_____

How do you control your head and neck symptoms? ☐cold / heat packs ☐physical therapy
☐diet change ☐anti-inflammatory ☐pain medication ☐limited jaw movement
☐injections-joint/mm ☐other_____

Have you had treatment for your-head and neck symptoms? ☐physical therapy
☐TMJ specialist ☐pain clinic ☐oral surgeon ☐orthodontist
☐general dentist ☐ENT ☐neurologist ☐splint
☐TMJ surgery ☐occlusal reconstruction ☐orthodontic care ☐equilibration
☐physical therapy ☐jaw surgery ☐other_____

How do you control your sleep apnea? ☐restrict alcohol beverages
☐restrict sedative medication ☐sleep upright ☐sleep on side
☐sleep on back ☐sleep with special pillow position

Have you had treatment for sleep apnea? ☐weight loss ☐c-pap
☐dental appliance ☐soft palate surgery ☐nasal surgery
☐other_____

Name:_____ Date:_____