SF BAY
ORAL SURGERY
& DENTAL IMPLANTS

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TMJ PATIENT HISTORY FORM

Patient Information

Last Name _____ First Name _____ Middle Ini. ____

Address _____ City, State, Zip _____

Date of Birth _____ SSN _____ Sex: Male or Female or Other

Home# _____ Work# _____ Cell# _____

Email Address: _____

Referred by _____ Tel# _____

In your own words, explain why you are here _____

_____

_____

Are you presently under the care of a physician or have you been in the past year? ☐ YES ☐ NO
Physician's name _____

Condition treated _____

Name any medication you are taking _____

_____

Dentist's name _____ Date of Last Appointment _____

Treatment prescribed _____

Do you have any problems with your jaw? ☐ YES ☐ NO
If yes, please describe _____

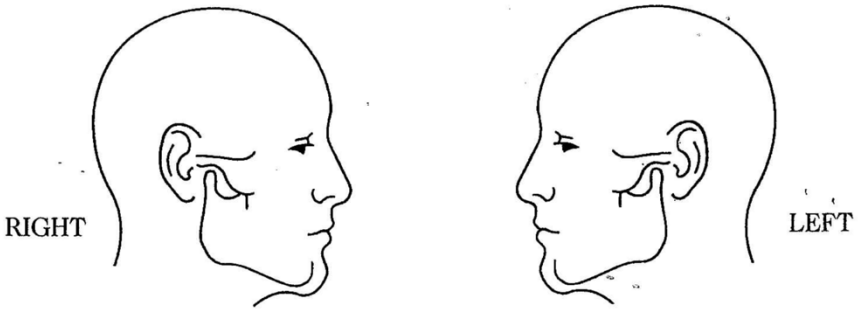
How long have you had these problems? _____

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
Blue splint	☐	☐	☐	☐	☐
Medication	☐	☐	☐	☐	☐
Physical therapy	☐	☐	☐	☐	☐
Occlusal adjustment	☐	☐	☐	☐	☐
Orthodontics	☐	☐	☐	☐	☐
Counseling	☐	☐	☐	☐	☐
Surgery	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

On the figures below: Mark an X where you have pain and circle the X where the pain is most severe.



When do you have this pain? _____

Do you do anything now to relieve your pain? ☐ YES ☐ NO If yes, what? _____

Do your jaw joints make noise? ☐ YES ☐ NO

RIGHT Clicking ☐ Popping ☐ Grinding ☐ Other _____

LEFT Clicking ☐ Popping ☐ Grinding ☐ Other _____

Has your jaw ever locked open? ☐ YES ☐ NO

When did this first occur? _____

How often has this occurred? _____

Has your jaw ever locked closed or partially closed? ☐ YES ☐ NO

When did this first occur? _____

How often has this occurred? _____

Have you ever injured your jaws? ☐ YES ☐ NO

When? _____

Please describe the injury _____

Do you consider yourself to be under more stress than most people? ☐ YES ☐ NO

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

_____

_____

_____