CMD - HISTORY- Taking Form

- Recommended by Lawrence D. Day, D.D.S., Ms. -

Diseases of the temporomandibular apparatus, The C. V. Mosby Company, Second Edition

CMD-Craniomandibular Dysfunction, the modern scientific term for TMJ-Temporomandibular Joint Diseases, or Costen Syndrome

Personal data

Date ________________ No.______________

Name (Mr./Mrs./Miss) ____
Last name First name Middle initial

Residence ______________________________________ Tel. ____________________
No. Street City State Zip Code Area Code

Occupation ______________________________________ Firm's name ____________________
If housewife, Write "Housewife" Leave blank, if housewife

Firm's address ______________________________________ Tel. ____________________
No. Street- City State Zip Code 90

Date of birth ______________ Marital Status ____________________ Ages of children ____________________

Spouse's name ____
Last name *First name* *Middle initial*

Spouse's occupation ____________________ Firm's name ____________________

Firm's address ______________________________________ Tel. ____________________
No. Street City State Zip Code

Referral from

Whom mal we thank for referring you to us? ____

Address ______________________________________ Tel. ____________________

Name of your regular physician ____

Address ______________________________________ Tel. ____________________

Name of your regular dentist ____

Address ______________________________________ Tel. ____________________

Treatments before

On the lines below please list any physicians, dentists, orthodontists, neurologists, ear, nose, and throat specialists, orthopedists, chiropractors, psychiatrists, or clinical teams you have consulted. Please also list their specialties. Briefly describe their diagnosis and treatment.

Dr. ______________________________ M.D./D.D.S. Specialty ____________________

Address ______________________________________ Tel. ____________________

Area Code

Diagnosis and treatment ____

____

Dr. ______________________________ M.D./D.D.S. Specialty ____________________

Address ______________________________________ Tel. ____________________

Area code

Diagnosis and treatment ____

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Dr. ______________________ M.D./D.D.S. Specialty ______________
Address ______________________ Tel. ______________
Area code
Diagnosis and treatment ______________________

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Diagnosis and treatment ______________________

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Address ______________________ Tel. ______________
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Diagnosis and treatment ______________________

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Dr. ______________________ M.D./D.D.S. Specialty ______________
Address ______________________ Tel. ______________
Area code

Diagnosis and treatment ______________________

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Medical Condition

Please answer as many of the following questions as possible by circling the disease or Symptom you have, its location, or "Yes" or "No." However, Write freely an the discussion questions.

1. GENERAL HEALTH

a. Have you had the following? Arthritis Osteoarthritis Rheumatoid arthritis
Sinus infection Ear infection Swollen glands Blood vessel disease

b. Do you have frequent headaches? What area of the head? ______________

How long do they last? ______________ Migraine? ______________

c. Have you ever had a severe blow to the head or had a whiplash injury? ______________
What part of the head? ______________ Date ______________

d. Have you ever suffered nutritional deficiencies? Yes No ______________

e. Do you regularly take any medication? Yes No Which? ______________
Are you allergic to any medication? Yes No Which? ______________

f. If you have any other current nondental physical problems or diseases, please describe them.

____

g. If you have any emotional problems regarding your teeth or jaws, please describe them.

____

h. Please indicate anything else about yourself that you suspect may be related to your condition.

____

2. CHIEF COMPLAINT

a. What is the main problem that brings you here? ______________

b. Did this problem begin suddenly or gradually? (Circle one)

c. How long have you been bothered by this problem? ______ Years /______ Months /______ Weeks /______ Days

d. Do Symptoms affect one or both sides? Right Left Both If both, which side seems most affected?

____

3. PAIN SYMPTOMS

Do you have *pain* in the following areas? Please circle R for right side or L for left side.

a. Joint R L
b. Ear R L
c. Upper teeth or jaw R L
d. Lower teeth or jaw R L
e. Tongue R L
f. Facial muscles R L
g. Eyes R L
h. Forehead R L
i. Neck R L
j. Shoulder R L

k. Circle kinds of pain you have:
Sharp Dull Aching Deep Superficial Burning Pulsating Spreading

l. Is the pain constant? Intermittent?
m. Does the pain last for a moment? Minutes? Hours? All day? Longer?
n. Does the pain start suddenly? Gradually?
o. Does the pain stop suddenly? Gradually?
p. What time of day or night is pain most severe? ______

q. How often do you have pain? ______

r. What is the longest period you have gone without pain? ______

______

s. What medication, if any, do you take to relieve pain?

______

t. Does rest increase or decrease pain? ______

u. Please describe any method of positioning the jaw or head that you have found for relieving pain.

______

v. Do any of the following normal daily activities cause pain? If yes, circle and indicate where you feel pain. Yawning
Chewing ______ Swallowing ______ Speaking ______

Singing ______ Shouting Brushing teeth ______ Moving head ______

Moving neck ______ Moving shoulders ______ Moving arms ______ Moving trunk ______

4. ORAL DYSFUNCTION

a. Can you open your mouth normally? Partially? Almost not at all?
b. Do you ever open so wide your mouth locks open? Yes No
c. Do you have any of these sounds in the joint?
Grating R L Clicking R L
Snapping R L Popping R L

d. If you have any of these Problems, is it frequent? Occasional? Constant?

e. Have you noticed any change in your bite? Any change in your ability to chew?

5. MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS

a. In which ear do you ever notice a hearing change? R L Ringing (tinnitus) R L
Fullness, Pressure, or blockage R L
b. Do you experience dizziness (vertigo)? Fainting? Nausea?
c. Are your jaws clenched or teeth sore when you awaken from sleep?
d. Do you grind your teeth (brux) when asleep?
When awake?
e. Do you clench or grind your teeth during moments of concentration?
f. Do you chew gum? Frequently Moderately Seldom Never

g. Are your jaw muscles ever tired? When? ______

______

h. Do you have a jaw thrust habit or nervous twitch about the face (tic)?
Where? ______ When? ______

i. Does your face swell? What part? ______ When? ______

j. Have you ever noticed production of more saliva or less saliva?
k. Do tears form in your eyes for no apparent reason?
l. Is there anyone else in your family with a similar problem? Yes No If yes, explain. ______

m. Did the symptoms start alter any of the following conditions?
Severe emotional upset Excessively large bite or yawn A blow an the jaw
Irregular or raised dental filling Prolonged or excessive opening during dental treatment
Traction for cervical arthritis or whiplash Accident General anaesthesia

n. Have you had your teeth straightened (orthodontia)? Yes No
o. Have you had your bite adjusted by your dentist? Yes No

p. Have you had cortisone injections in jaws or face? Yes No
q. Are you sensitive to metal rings or earrings? Yes No
r. Please describe briefly any changes in location or character of Symptoms since this problem began. ______

______

______

______

s. Please write any other pertinent information not covered above.

Finally, by referring back to the names of doctors, please answer:
6. Did any of their treatments make you feel better? If so, which helped the most? In what manner?

______

______

______

7. Did any of the treatments make you feel worse? Which ones? In what manner?

______

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