

Patient Name: \_\_\_\_\_

# Dental History Form

Please answer by CHECKING, CIRCLING and DESCRIBING ALL THAT APPLY:

YES NO

\_\_\_ \_\_\_ 1) Do you have frequent headaches or migraines? Scale: 1-10\_\_\_\_\_

\_\_\_ \_\_\_ 2) Do you have pain in or around the jaw joint? Scale: 1-10\_\_\_\_\_

Side: Right Left When did it first start?\_\_\_\_\_

\_\_\_ \_\_\_ 3) Has the pain recently become more severe?

\_\_\_ \_\_\_ 4) When is the pain worse? Mornings Evenings At Meals

\_\_\_ \_\_\_ 5) Do you have tired jaw muscles? Mornings Evenings

\_\_\_ \_\_\_ 6) Do you have tooth sensitivity? Cold\_\_\_ Air\_\_\_ Chewing\_\_\_ Tooth\_\_\_\_\_

\_\_\_ \_\_\_ 7) Do you have clicking, popping, or grating noises in your jaw joint?

Side: Right Left When did it first start?\_\_\_\_\_

\_\_\_ \_\_\_ 8) Does your jaw problem interfere with your normal activities?

\_\_\_ \_\_\_ 9) Have you had treatment for jaw problems? When\_\_\_\_\_ Where\_\_\_\_\_

\_\_\_ \_\_\_ 10) Are you taking, or have you taken, medication for your jaw joint?

\_\_\_ \_\_\_ 11) Are you taking antidepressants or any other medication that may effect muscle activity or cause dry mouth?

\_\_\_ \_\_\_ 12) Have you ever had a severe blow to the head, neck or jaw?

Explain:\_\_\_\_\_

\_\_\_ \_\_\_ 13) Do you have difficulty chewing? This is from: Pain in joint Pain in teeth

\_\_\_ \_\_\_ 14) Has your mouth ever locked open so you were unable to close? When?\_\_\_\_\_

\_\_\_ \_\_\_ 15) Are you aware of: clenching or grinding your teeth?

\_\_\_ \_\_\_ 16) Do you think nervous tension seems to affect this problem?

\_\_\_ \_\_\_ 17) Have there been recent changes in your lifestyle or stressful events?

\_\_\_ \_\_\_ 18) Have you had problems with other joints? Where?\_\_\_\_\_

\_\_\_ \_\_\_ 19) Have you had orthodontic treatment? When?\_\_\_\_\_