INLAND EMPIRE
ORAL & MAXILLOFACIAL SURGEONS
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TMJ/Facial Pain History

Date: ______________________________

Patient name: ____________________________________ ________Date of Birth: ____________________________________

How did you get referred to our practice ? ☐Dentist __________________ ☐Physician _______________________

☐ Internet ☐ Friend

What type of clinicans have treated your head and neck symptoms? ☐ physical therapist ☐ TMJ specialist

☐ pain clinic ☐ oral surgeon ☐ orthodontist ☐ general dentist ☐ ENT ☐ neurologist

What type of treatment have you had for your head and neck symptoms? ☐ splint ☐ TMJ arthrocentesis

☐ TMJ surgery ☐ occlusal reconstruction ☐ braces ☐ physical therapy ☐ jaw surgery ☐ other

How do you control your head and neck symptoms?

☐ cold/heat packs ☐ physical therapy ☐ diet change ☐ anti-inflammatory medication ☐ pain medication

☐ limited jaw movement ☐ other

I have the following habits: ☐ grinding during sleep ☐ clenching ☐ biting nails ☐ chewing gum

Have you had injury to your face, head, neck or jaw? ☐ Y ☐ N

Are you in an emotional or stressful period in your life? ☐ Y ☐ N

Are any of your arms, legs, feet, hands or finger joints painful, swollen or stiff? ☐ Y ☐ N

Have you ever taken steroid medications? ☐ Y ☐ N

Have you had any recent changes in your bite? ☐ Y ☐ N

Facial Pain History

How long have you been suffering with facial pain? ☐__________ years ☐ ____________ months

My pain is ☐intermittent ☐ constant

The pain is worse in the ☐ morning ☐ afternoon ☐ evening

The pain limits my ☐ eating ☐ speaking ☐ sleeping ☐ life in general

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My diet is: ☐ normal without pain ☐ normal with some pain ☐ normal with moderate amount of pain

☐ soft foods only ☐ I am mostly on liquids

My pain is localized:

☐ Right ☐ in my ears ☐ above my ears ☐ below my ears ☐ in front of my ears

☐ Left ☐ in my ears ☐ above my ears ☐ below my ears ☐ in front of my ears

Circle on photo your area(s) of pain (be as specific as possible):

On a scale of 1 to 10, how would you rate your pain (circle one number)…

Most of the time	(no pain) ☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (worst pain)
At its worst	(no pain) ☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (worst pain)
At its least	(no pain) ☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 (worst pain)

Disc History

What sounds do you hear in your joints when you open and close your mouth?

☐ Popping	☐ R	☐ L	☐ does not apply
☐ Clicking	☐ R	☐ L	☐ does not apply
☐ Grinding	☐ R	☐ L	☐ does not apply

Has the size of your mouth opening decreased? ☐ R ☐ L ☐ does not apply

Have you ever been stuck open and unable to close your mouth? ☐ R ☐ L ☐ does not apply

If yes, how many times? ☐ 1 time ☐ 2 times ☐ 3 times ☐ ≥ 4 times

Have you ever been stuck closed and unable to open your mouth? ☐ R ☐ L ☐ does not apply

If yes, how many times? ☐ 1 time ☐ 2 times ☐ 3 times ☐ ≥ 4 times

Please use the space below to describe your problem in your own words and previous treatments:

Patient Name: ______________________ Date: ______________________________