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- To enter in text, click in the area you wish to type in and begin typing.
- To check off choices on the form, click on the area you'd like to check.
- To send the completed form to our office, click "Submit" at the bottom of the last page.
- Feel free to print out a copy of the form before you send it to retain for your records.

If you experience difficulty submitting this form you can also print the blank form, fill out with black pen and bring the form to the office at the time of your appointment. If you do not have a printer you can fill out the form at the office at the time of your appointment.

Please fill out the form as completely as possible, and if you have any questions about this form please contact your doctor.

For your protection:

This form is hosted on a secure server and can only be viewed by our office. Please feel confident in filling out this form, as all of your information will be kept safe at every step of the process. *Your form will not be sent via email at any time to ensure the complete security of your information.*



David K. Hunter, DDS
 Dean B. Spingola, DMD, MD
 Craig E. Buchmann, DDS
 Diplomates of the American Board of
 Oral & Maxillofacial Surgery

TMJ, Oral & Facial History Form

Name _____ Date of Birth _____

- Please explain the reason for your visit. _____
- Are you currently under the care of or have you been in the care of a physician within the last year? Yes No
 If yes, please provide the following:
 Physician's Name _____ Treatment _____
 Condition Treated _____ Medications _____
- Dentist's Name _____ Date of Last Appointment: _____
 Treatment prescribed _____
- Please describe any problems with your jaws: _____
 _____ How long have you had these problems? _____
- If you have received treatment for jaw problems, please indicate the treatment you received:

Treatment	Yes	No	Results		
			Good	Fair	Poor
<i>Bit Splint</i>					
<i>Medication</i>					
<i>Physical Therapy</i>					
<i>Occlusal Adjustment</i>					
<i>Surgery</i>					
<i>Other (specify)</i>					

Who directed this treatment? _____

- Where is your pain?
 Ears In front of ears Behind Ears Eyes Jaws Teeth
 Neck Headache Nose Tongue Lips
 When is it worse? AM PM Does it wake you at night? Yes No
 Rank your pain on a scale from 1 to 10: Least 1 2 3 4 5 6 7 8 9 10 Worst
 Do you do anything to relieve your pain? Yes No If so, what? _____
 What makes your pain worse? _____

- Do your jaw joints make noise? Yes No
- | | | | | |
|--------------|-----------------------------------|----------------------------------|-----------------------------------|--------------------------------|
| Right | <input type="checkbox"/> Clicking | <input type="checkbox"/> Popping | <input type="checkbox"/> Grinding | <input type="checkbox"/> Other |
| Left | <input type="checkbox"/> Clicking | <input type="checkbox"/> Popping | <input type="checkbox"/> Grinding | <input type="checkbox"/> Other |

- Has your jaw ever locked? Yes No If yes, when did it occur and how often has it occurred?

- 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 your diagnosis or treatment.

Patient Signature and Date _____