



TMJ DENTAL HISTORY

Patient Name: _____ Date: _____

Date of last dental visit? _____ Last dental cleaning? _____ Last Full Mouth X-rays? _____

Previous Dentist's Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

How often do you have your dental examination? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Sonicare, Braun, toothpick, proxybrush, endtuft, etc.)? _____

Do you have active dental problems now? Yes No

Gum disease? Yes No

Bleeding gums? Yes No

Tooth decay? Yes No

Broken teeth? Yes No

Do you have trouble with bad breath? Yes No

Do you have any loose teeth? Yes No

Where? _____

Have you ever had:

Orthodontics treatment? Yes No

Oral surgery or teeth removed? Yes No

Periodontal treatment? Yes No

Endodontic treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

Have you ever had general anesthesia? Yes No

Have you ever had a broken jaw? Yes No

Do you have missing back teeth with no replacement? Yes No

Have you ever had cortisone injected into joints? * Yes No

*If yes, when? _____ How many injections? _____

By whom? _____

Have you ever had a bite plate, splint or mouth guard? * Yes No

*If yes, please describe? _____



DENTAL HISTORY

Patient Name: _____ Date: _____

OCCLUSAL HABITS

Do you clench or grind your teeth?..... Yes No

If yes: AM PM

Do your teeth hit in front first?..... Yes No

Do you bite your cheek?..... Yes No

Do you smoke a pipe?..... Yes No

Do you bite your nails?..... Yes No

Have previous dentists had difficulty getting you numb?..... Yes No

Do you have tired jaws, especially in the morning?..... Yes No

Do you chew gum?..... Yes No

Do you bite pencils?..... Yes No

Other? _____

Are any of your teeth sensitive to:

Hot or cold?..... Yes No

Sweets?..... Yes No

Biting or chewing?..... Yes No

Cold sores, blisters, or any other oral lesions?..... Yes No

Have you noticed any mouth odors or bad tastes?..... Yes No

Have you experienced gum disease or tooth loss?..... Yes No

Have you noticed any loose teeth or a change in your bite?..... Yes No

Does food tend to get caught between your teeth?..... Yes No

If yes, where? _____

Have you ever experienced:

Prolonged bleeding either from a cut or a dental procedure such as a cleaning?..... Yes No

Have you ever been involved in an accident or injury (includes sports injury, serious slips or falls, ski accidents, etc.)?..... Yes No

If yes, when? _____

What happened? _____

Did the symptoms start after this accident?..... Yes No

If yes, please explain: _____

Is the symptom(s) due to an illness, injury or work-related accident?..... Yes No

Place of the accident or injury? _____ Date/time of accident _____

Please explain: _____

Have you had:

Recent x-rays? Full mouth series Jaw Joints MRI CT Scans When? _____ Date of last eye exam: _____