TMJ Pain Solutions Patient History and Symptom Check List

Name_____ DOB_____ Date _____

HPI: Please check the symptoms you are currently having or you would like to discuss

- ☐ Jaw/facial Pain
- ☐ Headaches
- ☐ Clicking/Popping/ Jaw joint noises
- ☐ Ear Pain
- ☐ Tinnitus (ringing in the ears)
- ☐ Neck Pain
- ☐ Numbness or tingling
- ☐ Sinus Pain/ Pressure
- ☐ Tooth Pain
- ☐ Other_____

REVIEW OF SYSTEMS: Please **Circle** any that apply to your past or current health condition:

System	Examples
Constitutional	Weight loss/gain, fatigue, changes in sleep patterns, fever, recent trauma, unusual swelling or lumps, weakness, memory issues
Eyes	Vision changes, eye pain, double vision, light sensitivity, glaucoma
Ear, Nose, Nose, Throat, Mouth	Frequent nose bleeds, nasal congestion, sinus pain, stuffy ears, ear pain, ringing in ears, vertigo, bleeding gums, tooth pain, pain/difficulty swallowing
Cardiovascular	Chest pain, shortness of breath, palpitations, feeling faint, swelling in legs/feet, heart murmur, stroke, heart attack, HBP, high cholesterol
Respiratory	Cough, shortness of breath, asthma, emphysema, pneumonia hx, TB, snoring, sleep apnea
Gastrointestinal/Stomach	Nausea/ vomiting, reflux, ulcers, pain, Crohn's, gluten intolerance, Colitis
Genitourinary	Pregnancy 1st, 2nd,3rd Tri, birth control, menopause, hysterectomy, prostate issues, waking frequently to urinate, bladder issues, kidney stones
Musculoskeletal	Joint swelling, muscle/joint stiffness, joint disfiguration, pain, arthritis, fibromyalgia, Lyme's disease
Integumentary/Skin	Rashes, lesions, open wounds, eczema, excessive dryness, changes in size/color of mole
Neurological	Changes in sight/smell/taste, seizures, fainting/dizziness, headaches, migraines, numbness/tingling, limb weakness, speech problems, coordination issues, epilepsy, MS, Parkinson's, concussion/ TBI
Psychiatric	Depression, anxiety, bipolar disorder, ADHD, suicidal ideation, anger, work or school performance issues, worry, panic, mood changes
Endocrine	Diabetes, hypothyroid, hyperthyroid, Graves disease, adrenal insufficiency, hot/cold intolerance, abnormal weight loss/gain, excessive thirst
Hematologic/Lymphatic	Bruises easily, excessive bleeding, family hx hemophilia, HIV, hepatitis, blood thinners, Leukemia/ Lymphoma
Allergic/ Autoimmune	Seasonal allergies, food, latex, materials, animals, RA, Lupus, Cancer_____, Other_____

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Name_____ DOB_____ Date _____

PAST MEDICAL HISTORY:
Previous Surgeries: List all surgeries, including dates:

_____
_____
_____

List all medications taken, including over the counter, and the dose

_____
_____
_____
_____

Medication Allergies (Please list medication and reaction)_____
_____
_____

History of Trauma to the head or neck (Describe)_____
_____
_____

FAMILY HISTORY: Indicate any family history of the following conditions
(i.e. parent, grandparent, sibling)

Arthritis Migraine HA Heart Disease Stroke Cancer Diabetes

SOCIAL HISTORY:

Do you sleep well?	Y	N	
Can you eat comfortably?	Y	N	
Do you exercise regularly?	Y	N	_____Frequency
Smoke?	Y	N	_____ Packs per day/ week
Drink alcohol?	Y	N	_____ drinks per day/ week/ mo
Chew gum?	Y	N	None daily weekly
Average Stress Level		Low	Moderate High
Due to	Work	Family	Health Finances Other_____
Does stress affect your pain	Y	N	

_____
Patient/ Guardian Signature

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