David E. Lindeman, D.D.S., M.S.

To help us understand your problem and give you the best care possible, Please read the questions and answer each one as thoroughly as possible. Bring this form along with your health history form to your appointment on ______________. Please be prompt for your appointment. If for any reason you cannot make your scheduled appointment, please call at your earliest convenience.

Today's Date: ________________________

Date of Birth: __________________ Age______ Home Phone: _______________
Name: ____________________________________ Male ☐ Female ☐
Address:
____
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Occupation: ____________________________ Business Phone: _______________
Education: High School ☐ Junior College ☐ 4 year College ☐ Graduate School ☐
Family Dentist (address & phone): _______________________________________
Family Physician (address & phone): _____________________________________
Referred by: __________________________________

Please answer the following questions as completely as possible:

1. When was the pain first noticed?_______________________________________

2. Did anything occur which might be related to the onset of this problem? _____
Please explain:____

3. Is the pain: Dull ☐ Stabbing ☐ Continuous ☐ Intermittent ☐ Throbbing ☐
Other ☐

4. Please indicate the time sequence in which you became aware of the following problems. (1st, 2nd, 3rd,) Number only those which apply to you.
Pain____ Clicking _____ Limited Opening _____ Locking _____ Other ______

5. Has the noise or pain ever disappeared? _____ When? _______ Where? ________

6. Have you had x-rays taken for this problem? ____ When? _____ Where?____

TMJ QUESTIONNAIRE (CONT.)

HEAD, NECK AND FACE SYMPTOMS

1.	Painful or sore teeth	Yes	No
2.	Oral surgery	Yes	No
3.	Wisdom teeth removed	Yes	No
4.	Teeth ground by dentist	Yes	No
5.	Chew gum	Yes	No
6.	Orthodontic treatment	Yes	No
7.	Treated for bad bite	Yes	No
8.	Any badly worn teeth	Yes	No
9.	Any teeth extracted	Yes	No
10.	Accident to teeth	Yes	No
11.	Treated with a splint	Yes	No
12.	Treated for jaw joint muscle spasms	Yes	No

PAIN

1.	Tension headaches	Yes	No
2.	Migraine headaches	Yes	No
3.	Chronic headaches	Yes	No
4.	Headaches in left or right temple	Yes	No
5.	Inconsistent (jaw) pain	Yes	No
6.	Dull, aching pain	Yes	No
7.	Sharp, stabbing pain	Yes	No
8.	Arthritis	Yes	No
9.	Pain in other joints	Yes	No
10.	Medicine taken for pain	Yes	No

Never
Very seldom
Fairly often
Often
Regularly

11.	Teeth pain when awakening	Yes	No
12.	Chronic stiff neck	Yes	No
13.	Hurts to open wide	Yes	No
14.	Hurts to chew	Yes	No

15. Symptoms worse:
Morning
At work
At end of work day
At school
At home

16. Type of medicine taken
Aspirin
Tylenol
Advil
Motrin
Muscle relaxants
Other

TRAUMA

1.	Accident/trauma to head	Yes	No
2.	Accident/trauma to face	Yes	No
3.	Accident/trauma to jaw	Yes	No
4.	Accident/trauma to neck	Yes	No
5.	Whiplash neck injury	Yes	No
6.	Severe blow to side of head or jaw (ever)	Yes	No
7.	Fall (within last three years)	Yes	No

TMJ QUESTIONNAIRE (CONT.)

In the space below, please describe your current condition and detail the events, which you believe, led to this condition: