PATIENT INFORMATION ADDENDUM

Please answer the following questions as completely and accurately as you can. Also, please be as detailed as possible, providing additional information you think is important. If you have any questions about this form, or your upcoming appointment, contact our office for assistance.

Please circle YES or NO. If YES, please explain on the line provided.

DENTAL HISTORY

When was your last dental visit? _____

YES NO Have you been told that you have periodontal (gum) disease?
YES NO Do you have any existing problems with your teeth? Describe _____
YES NO Is any dental treatment planned? Describe _____
YES NO Do you bite your nails? _____
YES NO Have you ever had oral surgery?
YES NO Have you lost any teeth? From what cause? _____
YES NO Have the teeth been replaced? When? _____
YES NO Have you ever had orthodontic treatment? When? _____
YES NO Have you ever had extensive dental treatment? When? _____
YES NO Is any part of your mouth sensitive to temperature, pressure, food or drink?
Where? _____
YES NO Do you wear dentures or partial dentures? Are they comfortable? YES NO

TMJ HISTORY

YES NO Do you ever have a burning or painflul sensation in your mouth?
YES NO Do you get popping, clicking, or grinding noises when you open or close?
YES NO Do you ever awaken with an awareness of your teeth or jaws?
YES NO Are you aware of clenching during the daytime? How often?
YES NO Have you ever been told you grind your teeth during sleep?
YES NO Do you have trouble opening your mouth widely?
YES NO Does your jaw ever lock open or closed? How often? _____
YES NO Do you feel your bite is different, unstable or uncomfortable?
What professional advice or treatment have you had regarding your TMJ, headaches or pain conditions/problems? _____
YES NO If you sought treatment for a TMJ problem, did it help?
YES NO Do you or have you had any pain in any of the following areas? (circle)
Jaw Ear Face Neck Teeth Head Other _____
YES NO Do your jaw problems affect your ability to chew?
YES NO Has your diet changed due to your jaw problems? Describe _____
YES NO Do your joint noises affect others while eating?

FAMILY HISTORY:

YES NO Do you have children. What are their ages? _____
YES NO Does your partner help you?
YES NO Does your job satisfy you?
Women
YES NO Have you reached menopause?

Patient Signature _____ DATE _____

When did your symptoms first start?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing, after treatment that you are not able to do now?

Please use this space to tell us anything about your condition(s) that were not mentioned in this questionnaire

Patient Signature _____ DATE _____