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DIPLOMATES OF THE AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

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Name _____ Date of Birth _____

1. Please explain the reason for your visit. _____

2. Are you currently under the care of or have 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 _____

3. Dentist's Name _____ Date of Last Appointment: _____
   Treatment prescribed _____

4. Please describe any problems with your jaw: _____
   How long have you had these problems? _____

5. If you have received treatment for jaw problems, please indicate the treatment you received:

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

Who directed this treatment? _____

6. Where is the 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 Worse

   Do you do anything to relieve your pain? ☐Yes ☐No If so, what? _____
   What makes the pain worse? _____

7. Do your jaw joints make noise? ☐Yes ☐No

☐Right	☐Clicking	☐Popping	☐Grinding	☐Other
☐Left	☐Clicking	☐Popping	☐Grinding	☐Other

8. Has your jaw every locked? Yes No If yes, when did it occur and how often has it occurred?
_____

9. Do you consider yourself to be under more stress than most people? ☐Yes ☐No
10. Please provide any additional information you feel may be helpful in your diagnosis or treatment.
_____

Patient Signature and Date _____

◆ ···*Dental Implants*···*Wisdom Teeth*···*Dentoalveolar Surgery*···*Extractions*···*Pathology*···*Corrective Jaw Procedures*···*Reconstruction*···*Trauma*···◆

TMJ Evaluation Form

VO pain free _____ mm	Max Opening _____ mm
Deviation opening: None	RT _____ mm LT _____ mm
Lateral Movement:	RT _____ mm LT _____ mm
Protrusive: _____ mm Deviation	RT _____ mm LT _____ mm
Joint Sounds: Click Pop	RT _____ mm LT _____ mm RT _____ mm LT _____ mm

Lock: Yes or No

Translation: NL	RT	LT
Joint Pain: Lateral	RT	LT
Ear	RT	LT
Muscle Pain: Temporalis	RT	LT
Masseter	RT	LT
Ptergoid	RT	LT
SCM	RT	LT
Cervical	RT	LT
Coronoid	RT	LT
Oral Exam: Occlusion:	Class I_____ Class II_____ Class III_____	

Cross bite: Yes or No Wear: Yes or No

Missing Teeth: _____

Neurologic Exam: Trigger Points Yes or No Location _____

Assessment: Articular Disc Disorder 524.63; Myalgia & Myositis 729.1;

Capsulitis 726.90, Dislocation 830.0

Images: PANO TOMO CEPH MRI ICAT

Plan: MRI ICSH TCMC OTHER

ARTHROSCOPY ARTHROPLASTY ARTHROCENTESIS

Facility: ICSH TCMC OTHER