Zaytoun Orthodontics

Henry S. Zaytoun, D.D.S., M.S.O.
Mary Paula Zaytoun Steele, D.D.S., M.S.O.
Henry S. Zaytoun, Jr., D.D.S., M.S.O.
Diplomates of the American Board of Orthodontics

TMJ PATIENT HISTORY FORM

In order for us to be as informative as possible concerning your condition, please complete these forms.

Date __________ **Chart #_____________**

1. Name_____________________ **Date of Birth_____________**

2. In your own words, explain why you are here
____
____.

3. Are you presently under the care of a physician or have you been in the past year? Yes No

Physician's name ____
Condition treated ____
Treatment ____
Name of any medication you are taking ___________________________________
____.

4. Dentist's name ____
Date of last dental appointment ____
Treatment prescribed ____

5. Do you have any problems with your jaw? Yes No
If yes, please describe ____
____
How long have you had these problems? __________________________________

6. Have you received treatment for jaw problems? Yes No
Who directed this treatment? ____
Please describe the treatment. ____
____

7. Have you ever had orthodontic treatment? Yes No
If so, when? ____

8. Do you do anything now to relieve your pain? Yes No
If yes, what? ____

9. Are you aware of anything that makes the pain worse? Yes No
If yes, what? ____

10. Do your jaws make noises? Yes No

Right	**clicking**	**popping**	**grinding**	**other**
Left	**clicking**	**popping**	**grinding**	**other**

11. Has your jaw ever locked open? Yes No
When did this first occur? ____
How often has this occurred? ____

12. Has your jaw ever locked closed or partly closed? Yes No
When did this first occur? ____
How often has this occurred? ____

13. Have you ever injured your jaws? Yes No
When? ____
Please describe the injury____

14. Do you consider yourself to be under more stress than most people? Yes No

15. Please provide any additional information you feel may be helpful in the diagnosis or treatment of your condition. ___________________________________
____
____

16. Using the figures below: Mark an X where you have pain
Circle the X where the pain is most severe.