TEMPOROMANDIBULAR JOINT PAIN DYSFUNCTION SYNDROME

DENTIST'S DETAILS *(practice stamp)*						
Patient's Name						
Title: Mr / Mrs / Ms / Dr / Other						
Patient's date of birth and age						
Patient's sex *(please tick)*			M		F	
Any related medications *(please give details)?*						
Is there any relevant medical history *(please state)?*						
Is the patient edentulous *(please tick box)?*			Y		N	
How long the specific problem has been present?						
Is the pain worse on waking?			Y		N	
Does it increase in severity during the day?			Y		N	
Is this a severe acute episode?			Y		N	
Does the patient have associated trismus?			Y		N	
Tenderness of TMJ on palpation?			Y		N	
Tenderness of muscles of mastication?			Y		N	
Deviation on opening?			Y		N	
Deviation on closing?			Y		N	
History of bruxism?			Y		N	
Discomfort on opening?			Y		N	
Discomfort on closing?			Y		N	
Clicking or locking on opening?			Y		N	
Clicking or locking on closing?			Y		N	
History of jaw dislocation?			Y		N	
History of previous trauma to jaw?			Y		N	
Have radiographs been taken; if so please enclose?*			Y		N	
Has the patient received any explanation as to their diagnosis?			Y		N	
Has the patient received any specific advice/treatment for the problem?			Y		N	
Exercises?			Y		N	
Provision of a POC: *(please circle)?*	Hard	Soft	Upper		Lower	
Provision of new:*(please circle)?*	F/F		Partial denture			
Has the patient been seen by other medical specialists?			Y		N	

*RADIOGRAPHS WILL BE RETURNED