ARTHUR M STRAUSS D·D·S

SPECIAL INTEREST IN
MANAGEMENT OF SNORING & SLEEP APNEA,
RESTORATION OF ORAL SYSTEMIC BALANCE

COMPREHENSIVE DENTAL CARE EMPHASIZING
PREVENTION, RESTORATION, AESTHETICS

Temporomandibular Joint History

NAME_____ DATE______

Please answer the following questions by indicating frequency according to the following guidelines:

Always = A = every or almost every night or day
Often = O = at least once a week but less than "always"
Seldom = S = less than once a week
Never = N = never during a usual night or day

Circle the appropriate letter.

Do you have any of the following symptoms?

1. Headaches..... A O S N
2. Dizziness..... A O S N
3. Lightheadedness..... A O S N
4. Ringing or buzzing in the ear..... A O S N
5. Sinuses or ears feel filled..... A O S N
6. Numbness or tingling of fingertips..... A O S N
7. Backaches (upper or lower)..... A O S N
8. Neck aches..... A O S N
9. Sounds from jaw joint (clicking, etc..)..... A O S N
10. Difficulty opening or closing mouth..... A O S N
11. Pain from the jaw joint..... A O S N
12. Pain in the facial muscles..... A O S N
13. Pain in the upper or lower teeth..... A O S N
14. Easily fatigued at the end of the day..... A O S N
15. Sore throat..... A O S N
16. Difficulty in remembering and learning..... A O S N
17. Inability to fully open your mouth..... A O S N
18. Pain in the eye or visual problems..... A O S N
19. Encounter stressful situations..... A O S N

Additional Comments:

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