TMJ SYNDROME AND MYOFASCIAL PAIN HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth/Age: _____

Sex: M or F (circle one) SSN or SIN: _____

Address: _____ City: _____

State/Province: _____ Zip/Postal Code: _____

CHIEF COMPLAINT(S)

1) Describe what you think the problem is: _____

2) What do you think caused this problem? _____

3) Describe, in order (first to last), what you expect from your treatment: _____

_____

MEDICAL AND DENTAL HISTORY

1) Are you presently under the care of a physician or have you been in the past year? Yes ☐ No ☐

Physician's name: _____ Condition(s) treated: _____

_____

TREATMENT

Name of medication(s) you are currently taking: _____

_____

2) How would you describe your overall physical health? (circle one) Poor Average Excellent

3) How would you describe your dental health? (circle one) Poor Average Excellent

Dentist's name: _____ Date of last appointment: _____

4) Have you had any major dental treatment in the last two years? (circle one) Yes ☐ No ☐

If yes, please mark procedure(s): Orthodontics ☐ Periodontics ☐ Oral Surgery ☐ Restorative ☐

Date(s) of Third Molar (wisdom tooth) extraction(s): _____

HISTORY OF INJURY AND TRAUMA

1) Is there any childhood history of falls, accidents of injury to the face of head? Yes ☐ No ☐

Describe: _____

2) Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact)

Yes ☐ No ☐ Describe: _____

3) Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument)

Yes ☐ No ☐ Describe: _____

FACIAL PAIN PAST TREATMENT

1) Have you ever been examined for a TMD problem before? Yes ☐ No ☐

If yes, by whom? When? _____

2) What was the nature of the problem? (Pain, noise, limitation of movement): _____

_____

3) What was the duration of the problem? Months? Years? _____

Is this a new problem? Yes ☐ No ☐

4) Is the problem getting better, worse or staying the same? _____

5) Have you ever had physical therapy for TMD? Yes ☐ No ☐ If yes, by whom? When? _____

_____

6) Have you ever received treatment for jaw problems? Yes ☐ NO ☐ If yes, by whom? When? _____

_____

What was the treatment? (Please mark Below)

Bite Splint Medication Physical Therapy Occlusal Adjustment Orthodontics

Counseling Surgery

Other ☐ (Please explain): _____

7) Have you ever had injections for your TMD with muscle relaxants (Botox, Flexeril) cortisone or anti-inflammatories?

Yes ☐ No ☐ If yes, were they effective? Yes ☐ No ☐

How many dental appliances have you worn? _____

8) Were these appliances effective? Yes ☐ No ☐

11) Is there any additional information that can help us in this area? _____

CURRENT STRESS FACTORS (PLEASE MARK EACH FACTOR THAT APPLIES TO YOU)

- ☐ Death of a Spouse
- ☐ Major Illness or Injury
- ☐ Major Health Change in Family
- ☐ Business Adjustment
- ☐ Divorce
- ☐ Pending Marriage
- ☐ Financial Problems
- ☐ Pregnancy
- ☐ Career Change
- ☐ Fired from Work
- ☐ Marital Reconcilliation
- ☐ Debt
- ☐ Death of a Family Member
- ☐ New Person Joins Family
- ☐ Marital Separation
- ☐ Other

CURRENT AND PREVIOUS HABITS (PLEASE MARK YOUR ANSWER TO EACH QUESTION)

1) Do you clench your teeth together under stress? ..... Yes ☐ No ☐ Don't Know ☐

2) Do you grind/clench your teeth at night? ..... Yes ☐ No ☐ Don't Know ☐

3) Do you sleep with an unusual head position? ..... Yes ☐ No ☐ Don't Know ☐

4) Are you aware of any habits or activities that may aggravate this condition? ..... Yes ☐ No ☐ Don't Know ☐

Describe: _____

CURRENT SYMPTOMS (PLEASE MARK EACH SYMPTOM THAT APPLIES)

A. HEAD PAIN, HEADACHES, FACIAL PAIN

Forehead L R

Temples L R

- ☐ Migraine Type Headaches
- ☐ Cluster Headaches Maxillary Sinus
- ☐ Headaches (under the eyes)
- ☐ Occipital Headaches (back of the head with or without shooting pain)
- ☐ Hair and/or Scalp Painful to Touch

B. EYE PAIN / EAR ORBITAL PROBLEMS

- ☐ Eye Pain - Above, Below or Behind
- ☐ Bloodshot Eyes
- ☐ Blurring of Vision
- ☐ Bulging Appearance
- ☐ Pressure Behind the Eyes
- ☐ Light Sensitivity
- ☐ Watering of the Eyes
- ☐ Drooping of the Eyelids

C. MOUTH, FACE, CHEEK & CHIN PROBLEMS

- ☐ Discomfort
- ☐ Limited Opening
- ☐ Inability to Open Smoothly

D. TEETH & GUM PROBLEMS

- ☐ Clenching, Grinding at Night
- ☐ Looseness and/or Soreness of Back Teeth
- ☐ Tooth Pain

E. JAW & JAW JOINT (TMD) PROBLEMS

- ☐ Clicking, Popping Jaw Joints
- ☐ Grating Sounds
- ☐ Jaw Locking Opened or Closed
- ☐ Pain in Cheek Muscles
- ☐ Uncontrollable Jaw/ Tongue Movements

F. PAIN, EAR PROBLEMS, POSTURAL IMBALANCES

- ☐ Hissing, Buzzing, or Ringing Sounds
- ☐ Ear Pain without Infection
- ☐ Clogged, Stuffy, Itchy Ears
- ☐ Balance Problems – "Vertigo"
- ☐ Diminished Hearing

G. NECK & SHOULDER PAIN

- ☐ Arm and Finger Tingling, Numbness, Pain
- ☐ Reduced Mobility and Range of Motion
- ☐ Stiffness
- ☐ Neck Pain
- ☐ Tired, Sore Neck Muscle
- ☐ Back Pain, Upper and Lower
- ☐ Shoulder Aches

H. THROAT PROBLEMS

- ☐ Swallowing Difficulties
- ☐ Tightness of Throat
- ☐ Sore Throat
- ☐ Voice Fluctuations

I. OTHER PAIN

_____

_____

_____

_____

_____

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED

NO PAIN MODERATE PAIN SEVERE PAIN

1) Degree of current TMD pain: 0 1 2 3 4 5 6 7 8 9 10

2) Frequency of TMD pain: Daily Weekly Monthly Semi-Annually After Eating

Is the pain constant, continuous, or intermittent? _____ How long does it last? _____

What is the quality of the pain? Sharp, dull, burning, aching, electircal, etc. _____

What makes it worse? _____

What makes it better? _____

How often does the pain occur? _____

Does the pain occur on it's own or do you need to trigger with function, touching, etc.? _____

If you were to place a Q-tip in your left ear and push forward, does that trigger pain? _____

_____

Can the pain be triggered by touching the skin with a light brush stroke with a Q-tip or pressing on an area with a Q-tip? _____

_____

3) Are you taking medication for the TMD problems? Yes ☐ No ☐ If so, what type? _____

_____

How long? _____ Who prescribed the medication? _____

4) Are the medications that you take effective? Yes ☐ No ☐ Conditional? _____

5) Are you aware of anything that makes your pain worse? Yes ☐ No ☐ If yes, what? _____

_____

6) Does your jaw make noise? Yes ☐ No ☐ If so, when and how? _____

Right ☐ Clicking/Popping ☐ Grinding ☐ Other ☐ _____

Left ☐ Clicking/Popping ☐ Grinding ☐ Other ☐ _____

7) Does your jaw lock open? Yes ☐ No ☐ If yes, when did this first occur? _____

How often? _____

8) Has your jaw ever locked closed or partly closed? Yes ☐ No ☐ If yes, when did this first occur? _____

How often? _____

9) Have any dental appliances been prescribed? Yes ☐ No ☐

If yes, by whom? _____

When? _____ Describe: _____

When do you wear your dental appliances? _____

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PATIENT _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox®, Xeomin) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); c) forehead wrinkles; d) radial lip lines (smokers lines), e) head and neck muscles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer.

Initial _____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1.Post treatment discomfort, swelling, redness, and bruising, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache and 9. Flu-like symptoms may occur.

Initial _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. **Initial** _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial _____

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PAYMENT
I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. **Initial** _____

RIGHT TO DISCONTINUE TREATMENT
I understand that I have the right to discontinue treatment at any time. **Initial** _____

TRAINING COURSE
I understand that I have volunteered to be a model patient in a training course and the doctor/healthcare professional who will be treating me has had limited experience with the method of treatment. **Initial** ____

I hereby indemnify the American Academy of Facial Esthetics LLC from any liability relating to the procedures that I have volunteered for. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. **Initial**_____

I hereby indemnify the facility/meeting room/hotel where this treatment is being performed from any liability relating to the procedures that I have volunteered for. **Initial**____

PUBLICITY MATERIALS
I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs. **Initial** _____

RESULTS
I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re- treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area (s) of the injections for the 4 hours post-injection period. **Initial** ____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Health History Completed? Yes ☐ No ☐ Date: _____ Provider Initial:____

Dental / Head and Neck Examination Completed? Yes ☐ No ☐ Date: _____ Provider Initial:

_____

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Patient Name (Print) Patient Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Provider Name (Print) Provider Signature Date

AAFE Trainer Name (Print) AAFE Trainer Signature Date

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BOTULINUM TOXIN PRE-TREATMENT INSTRUCTIONS

Please review and adhere to the following pre-treatment guidelines in preparation for your botulinum toxin appointment. The following restrictions are in place to minimize the risk for any potential complications

- Patient must be in good health with no active skin infections in the treatment area

- Avoid alcoholic and caffeinated beverages at least 24 hours prior to treatment. Alcohol may thin the blood which will increase the risk of bruising.

- Avoid anti-inflammatory / blood thinning medications ideally, for a period of two (2) weeks before treatment and for a few days following treatment. Medications and supplements such as Aspirin, Vitamin E, Ginkgo Biloba, St. John's Wort, Ibuprofen, Motrin, Advil, Aleve, Vioxx, and other NSAIDS all cause thinning of the blood and can increase the risk of bruising/swelling after injections.

- Schedule botulinum toxin appointments at least 2-4 weeks prior to a special event to avoid having bruising on the day of your event.