REYNOLDS
ORAL & FACIAL
SURGERY

TMJ
EVALUATION FORM

NAME:______________________________DATE:___________________AGE:______________

IN YOUR OWN WORDS PLEASE EXPLAIN WHY YOU ARE HERE: ______________________________

____

DATE PROBLEM BEGAN:______________ AGE PROBLEM BEGAN:______________________

PREVIOUS FACIAL INJURY? ☐ NO ☐ YES WHEN WAS THE INJURY?____________

IF YES, PLEASE GIVE DETAILS OF THE INJURY.______________________________________

____

PLEASE CHECK WHETHER YOU HAVE HAD ANY OF THE FOLLOWING:

			RESULTS: Good	Fair	Poor
☐	ORTHODONTICS	WHEN?____________	☐	☐	☐
☐	OCCLUSAL ADJUSTMENT	WHEN?____________	☐	☐	☐
☐	PHYSICAL THERAPY	WHEN?____________	☐	☐	☐
☐	TMJ SPLINT	WHEN?____________	☐	☐	☐
☐	TMJ ARTHROSCOPIC SURGERY	WHEN?____________	☐	☐	☐
☐	TMJ OPEN JOINT SURGERY	WHEN?____________	☐	☐	☐
☐	TMJ PROSTHETIC REPLACEMENT	WHEN?____________	☐	☐	☐

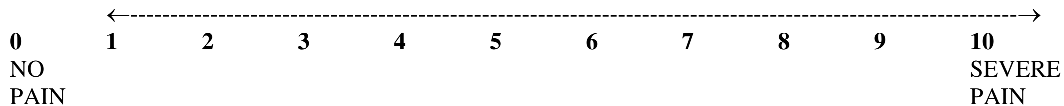
MEDICATIONS TAKEN IN THE PAST FOR TMJ:____

____

CURRENT MEDICATIONS FOR TMJ:____

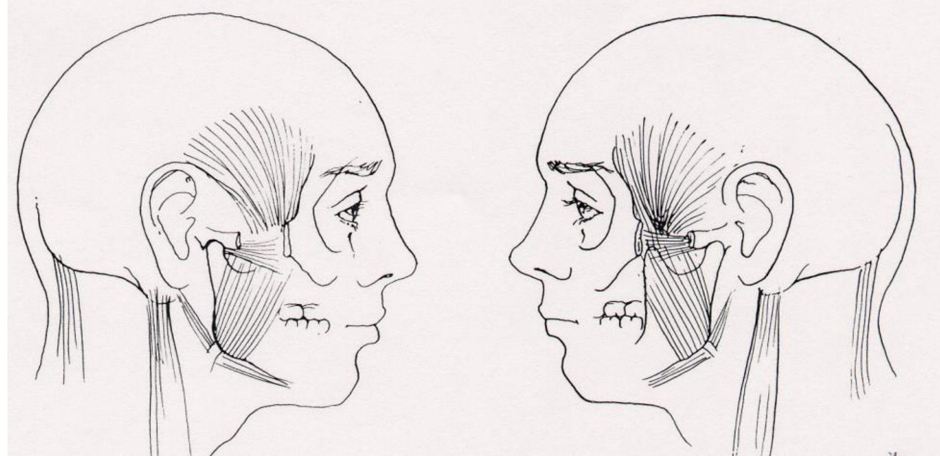
____

INDICATE ON THE FOLLOWING SCALE HOW SEVERE YOUR PAIN IS THE MAJORITY OF THE TIME.



0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
NO PAIN										SEVERE PAIN

PLEASE INDICATE WHERE YOU ARE HAVING PAIN ON THE DIAGRAM BELOW



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REYNOLDS ORAL & FACIAL SURGERY

TMJ EVALUATION FORM

IS THE PAIN CONSTANT OR INTERMITTENT? (CIRCLE ONE)

DOES IT HURT TO MOVE YOUR JAW? ☐ YES ☐ NO
TO CHEW? ☐ YES ☐ NO

DOES THE PAIN/PROBLEM LIMIT YOUR FUNCTION? ☐ YES ☐ NO
IF SO, HOW?____________________

WHEN IS THE PAIN WORSE? MORNING AFTERNOON EVENING (CIRCLE ONE)
OTHER TIME:____________________

DOES ANYTHING YOU DO MAKE THE PAIN WORSE?____________________
WHAT?____________________

DOES ANYTHING YOU DO MAKE THE PAIN BETTER?____________________
WHAT?____________________

WHAT OTHER DOCTORS OR HEALTH CARE ASSOCIATES HAVE YOU SEEN REGARDING THIS PAIN/PROBLEM?_
____

DOES YOUR JAW EVER LOCK OPEN?__________ CLOSED?__________
HOW HAS THIS BEEN TREATED?____________________
CAN YOU DO ANYTHING TO PREVENT OR TREAT THIS?____________________

DO YOU GRIND OR GRIT YOUR TEETH? ☐ YES ☐ NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

SINUS PROBLEMS______	HEARING CHANGES______	STRESSFUL JOB______
SENSITIVE TEETH______	RINGING IN EARS______	MARITAL PROBLEMS______
PERIODONTAL DISEASE______	DIZZINESS______	TROUBLE SLEEPING______
HEADACHES______	SHOULDER PAIN______	ULCERS______
MIGRAINES______	ARTHRITIS______	NERVOUS STOMACH______
NECK ACHE______	SKIN DISEASES______	ALLERGIES______
EAR ACHE______	DEPRESSION______	to WHAT?______

LIST OTHER MEDICAL PROBLEMS:____________________

____

____

____

THE PAIN IS HAVING THIS EFFECT ON MY LIFE.

←|-----------|-----------|-----------|-----------|→

0 1 2 3 4 5 6 7 8 9 10

NO EFFECT	SLIGHT EFFECT I can work/play but I am aware of pain	MODERATE EFFECT Some days I cannot function	SEVERE EFFECT Most days cannot function	CANNOT FUNCTION AT ALL

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EVALUATION FORM

EXAMINATION

(TO BE COMPLETED BY THE DOCTOR)

EXAM: OCCLUSION

☐ CL I ☐ CL II ☐ CL III

☐ (R) CROSSBITE ☐ (L) CROSSBITE ☐ OPEN BITE

UPPER INCISOR SHOW AT REST __________MM

UPPER INCISOR SHOW AT HIGHSMILE ______MM

OVERBITE__________MM OVERJET__________MM

MAXILLARY MIDLINE___________

MANDIBULAR MIDLINE__________

INTERFERENCES ON EXCURSION:
RIGHT EXCURSION __________ LEFT EXCURSION_________ PROTRUSION________

TMJ: MAXIMUM INTERINCISAL OPENING__________MM

MAXIMUM INTERINCISAL OPENING WITHOUT PAIN__________MM

(R) LATERAL EXCURSION ___________MM

(L) LATERAL EXCURSION____________MM

DEVIATION ON OPENING

JOINT NOISE

OPENING POP	☐ **(R)**	☐ **(L)**
CLOSING POP	☐ **(R)**	☐ **(L)**
CREPITATION	☐ **(R)**	☐ **(L)**

Tenderness to palpation

TMJ	☐ **(R)**	☐ **(L)**
MASSETER	☐ **(R)**	☐ **(L)**
TEMPORALIS	☐ **(R)**	☐ **(L)**
MEDIAL PTERYGOID	☐ **(R)**	☐ **(L)**
LATERAL PTERYGOID	☐ **(R)**	☐ **(L)**
ANTERIOR NECK	☐ **(R)**	☐ **(L)**
STERNOCLEIDOMASTOID	☐ **(R)**	☐ **(L)**
POSTERIOR NECK	☐ **(R)**	☐ **(L)**

Other Findings:____

____

____

____

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