TMJ Consultation

CAROLINAS CENTER FOR
Oral & Facial Surgery

Patient's Name _____ Date _____

Approximate Date Your Pain Began _____ What, if Anything, Caused Your Pain? _____

Reason for Today's Consult (Please Check All That Apply)

○ **Difficulty Opening Your Mouth**

On a Scale of 1-10, Please Indicate How Difficult it is to Open Your Mouth with an X

1	2	3	4	5	6	7	8	9	10

No Difficulty Extremely Difficult

○ **Difficulty Chewing**

On a Scale of 1-10, Please Indicate How Difficult it is to Open Your Mouth with an X

1	2	3	4	5	6	7	8	9	10

No Difficulty Extremely Difficult

○ **Pain**

On a Scale of 1-10, Please Indicate Your Pain Level with an X

1	2	3	4	5	6	7	8	9	10

No Pain Most Intense Pain

On a Scale of 1-10, Please Indicate Your **Average Pain** Level with an X

1	2	3	4	5	6	7	8	9	10

No Pain Most Intense Pain

On a Scale of 1-10, Please Indicate Your **Highest Pain** Level with an X

1	2	3	4	5	6	7	8	9	10

No Pain Most Intense Pain

On a Scale of 1-10, Please Indicate Your **Lowest Pain** Level with an X

1	2	3	4	5	6	7	8	9	10

No Pain Most Intense Pain

CAROLINAS CENTER FOR
Oral & Facial Surgery

(Please Circle Where Your Pain is Located)

Approximately How Many Days Per Month do You Experience Your Main Pain

- ○ Every Day
- ○ Most Days
- ○ Some Days
- ○ Rarely

What has Helped Most with Your Pain?
(Please Specify)

Quality of Life

On a Scale of 1-10, Please Indicate How Much TMJ Affects Your Life with an X

1	2	3	4	5	6	7	8	9	10

No Change — Dramatic Change

Symptoms

What Other Symptoms are You Experiencing with Your Pain?
(Check All That Apply)

- ○ Neck Pain
- ○ Shoulder Pain
- ○ Ear Pain
- ○ Ringing Ears
- ○ Headaches
- ○ Mild Back Pain
- ○ Upper Back Pain
- ○ Knee Pain
- ○ Hip Pain
- ○ Hand Pain
- ○ Foot Pain
- ○ Ankle Pain
- ○ Elbow Pain
- ○ Other Joint Pain
- ○ Swelling
- ○ Depression
- ○ Dizziness
- ○ Fatigue
- ○ Stress
- ○ Anxiety
- ○ Vertigo
- ○ Poor Sleep
- ○ Jaw Pain or Tenderness
- ○ Jaw Clicking or Popping
- ○ Teeth Grinding

_____
Other

CAROLINAS CENTER FOR Oral & Facial Surgery

Treatments

Have You Ever Had Any TMJ Surgeries?
(Please Specify and Indicate if it was on Your Right or Left Side)

Procedure	Right Side	Left Side	Year
Arthrocentesis			
Arthroscopy			
Open Surgery for Disc Repositioning			
Discectomy (Your TMJ Disc was Removed)			
Total Joint Replacement			
Other			

List Any Scans, Imaging, Studies, or Doctor Visits Completed for Your Condition
(e.g., X-Rays, MRIs, Blood Work, Other Tests, or Types of Doctors Consulted)

Test / Study / Doctor Visit	Date	Brief Summary of Results

Do You Have Any Stress Management Practices?
(e.g., Exercise, Meditation, Therapy)

Do You Have Any Dietary Restrictions?
(Please Specify)

List Any Other Treatments You Have Had in the Past or are Receiving Currently

CAROLINAS CENTER FOR Oral & Facial Surgery

Which of the Following Have You Tried for Your Condition?
(Check All That Apply)

Treatment	Was it Helpful?		Using Currently?	
○ Mouth Guard	○ Yes	○ No	○ Yes	○ No
○ Diet (Eliminating Hard Foods / Maintaining Soft Foods)	○ Yes	○ No	○ Yes	○ No
○ Exercise or Stretches	○ Yes	○ No	○ Yes	○ No
○ Massage	○ Yes	○ No	○ Yes	○ No
○ Chiropractic	○ Yes	○ No	○ Yes	○ No
○ Dry Needling	○ Yes	○ No	○ Yes	○ No
○ Acupuncture	○ Yes	○ No	○ Yes	○ No
○ Laser Therapy	○ Yes	○ No	○ Yes	○ No
○ Steroids	○ Yes	○ No	○ Yes	○ No
○ Tylenol	○ Yes	○ No	○ Yes	○ No
○ Aspirin	○ Yes	○ No	○ Yes	○ No
○ Muscle Relaxants (e.g., Flexeril, Baclofen, Tizanidine, Lorzone)	○ Yes	○ No	○ Yes	○ No
○ Opioids (e.g., Oxycodone)	○ Yes	○ No	○ Yes	○ No
○ Other (e.g., Amitriptyline, Gabapentinoid, Benzodiazepines)	○ Yes	○ No	○ Yes	○ No
○ Anti-Inflammatories (e.g., Ibuprofen (Motrin / Advil) Naproxen (Aleve), Diclofenac (Voltaren), or Other NSAIDS)	○ Yes	○ No	○ Yes	○ No

_____
How Many Weeks Total (Cumulative) Have You Used Anti-Inflammatory Medications for Your Condition?

○ Botox	○ Yes	○ No	○ Yes	○ No

_____ _____ _____
How Many Units Were Given? Which Locations Were Injected? How Many Treatments?

Is There Anything Else You Would Like to Share About Your Issues with TMJ?

Do You Smoke?
○ Yes
○ No

_____
Number of Cigarettes per Day

Do You Drink Alcohol?
○ Yes
○ No

_____
Number of Drinks per Week

CAROLINAS CENTER FOR Oral & Facial Surgery

Additional Medical History Information

Do You Have Any of the Following Medical Conditions?
(Check All That Apply)

- ○ Diabetes
- ○ GERD
- ○ Anxiety
- ○ Depression
- ○ High Blood Pressure
- ○ Heart Disease
- ○ Osteoporosis
- ○ Kidney Disease
- ○ Liver Disease
- ○ Cancer
- ○ Asthma
- ○ Arthritis
- ○ Rheumatoid Arthritis
- ○ Juvenile Idiopathic Arthritis
- ○ Psoriatic Arthritis
- ○ Ankylosing Spondylitis
- ○ Gout

_____
Other

Do You Have Any Allergies?

- ○ No
- ○ Yes

(Check All That Apply)

- ○ Penicillin
- ○ Anti-Inflammatory
- ○ Sulfa
- ○ Opioids
- ○ Local Anesthetics

_____
Other

Are You Currently Taking Any Medications?
(Check All That Apply)

- ○ **Statins** to Lower Cholesterol Levels (e.g., Atorvastatin, Simvastatin)
- ○ **Antihypertensives** for High Blood Pressure (e.g., Lisinopril, Amlodipine)
- ○ **Antidepressants** for Depression and Anxiety (e.g., Sertraline, Fluoxetine)
- ○ **Metformin** for Type 2 Diabetes
- ○ **Insulin** for Type 1 Diabetes
- ○ **Asthma Medications** (e.g., Flovent, Pulmicort, Proair, Ventolin)
- ○ **Levothyroxine** for Hypothyroidism
- ○ **Pain Relievers** Over-the-Counter (e.g., Ibuprofen, Acetaminophen) or Prescription Opioids
- ○ **Proton Pump Inhibitors (PPIs)** for Acid Reflux and Gastrointestinal Issues (e.g., Omeprazole)
- ○ **Antibiotics** for infections (e.g., Amoxicillin)
- ○ **Blood Thinners** to Prevent or Treat Blood Clots in the Heart, Blood Vessels, or Lungs (e.g., Eliquis, AAS, Xarelto, Pradaxa, Coumadin)

Have You Had Any Surgeries?
(Please Specify)

Procedure	Year	Procedure	Year
C-Section		Bariatric Surgery	
Hip or Knee Replacement		Coronary Bypass Surgery	
Gallbladder Removal		Appendix Removal	
Tonsil Removal		Cataract Surgery	
Thyroid Surgery		Hernia Repair	
Other			