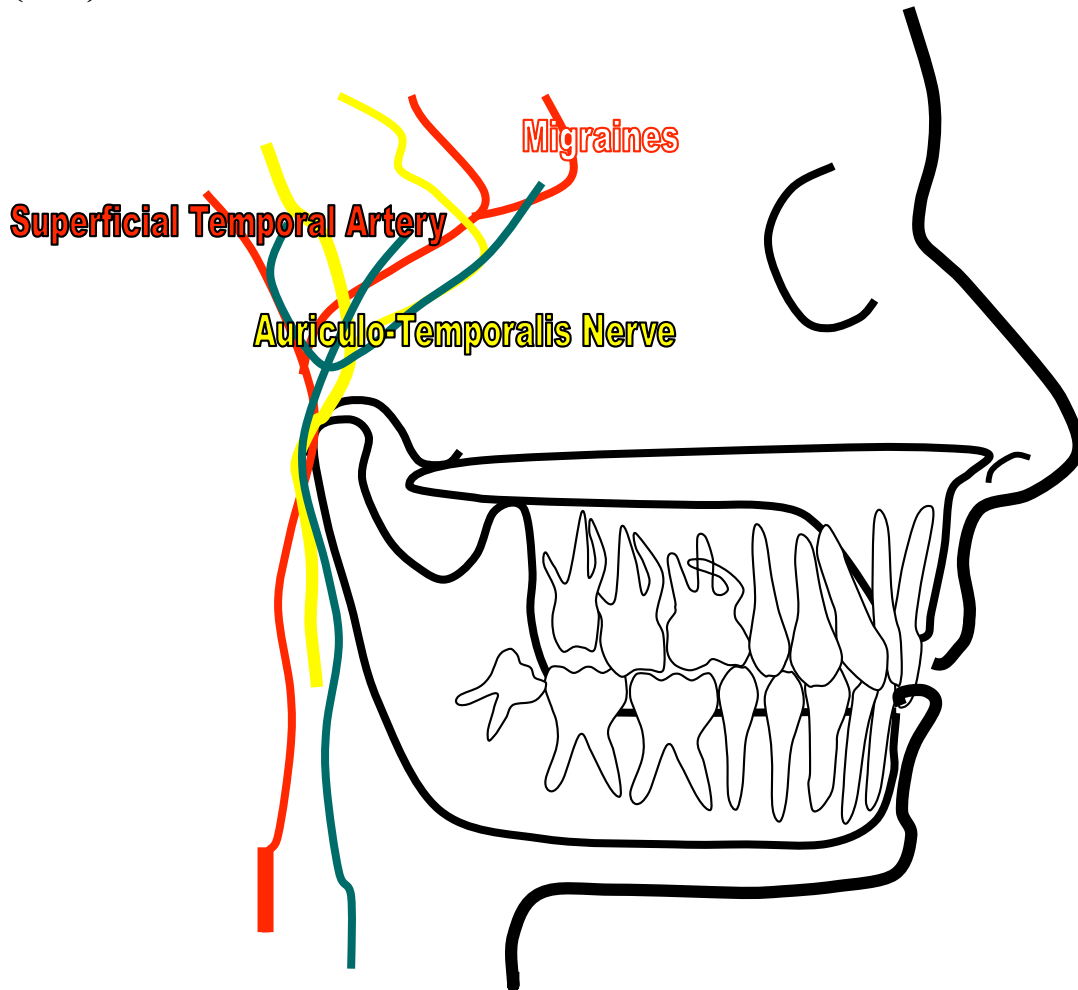


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TMJ Dysfunctions
Head and Neck Pain
Dental Treatment Center

Changing Peoples' lives, one at a time...

General Health Questions:

Please answer as many of these general health questions as possible with “Yes” or “No.” However, write freely on the discussion questions.

- A. Sinus Infection? _____ Ear Infections? _____ Swollen Glands? _____
- B. Do you have frequent headaches? _____ What area of the head? _____
How long do they last? _____ Number of Headaches per Week? _____
Do you ever have Headaches that last for days? _____
At what age did your headaches start? _____
- C. Have you ever had a severe blow to the head or neck? _____
- D. Have you ever suffered nutritional Deficiencies? _____
- E. Do you regularly take any medications? _____ Which? _____
- F. Please indicate anything else about yourself which you suspect may be related to your condition. _____
- G. Do you have Migraines? _____ Did your Medical Doctor diagnose it? _____
- H. During a Migraine do you: Vomit? _____ Have Sound Sensitivities? _____
Light sensitivities? _____ Decreased Appetite? _____ Eye Pain? _____
- I. Are your headaches (increasing/decreasing/same) in frequency? _____
- J. Are your headaches (increasing/decreasing/same) in intensity? _____
- K. What type of headaches do you have? Tension, Cluster, Stress, low blood sugar or Migraine.
- L. What time of the day do your headaches start? Morning, Afternoon, evening, bed time or the middle of the night. _____
- M. Do you have soreness of the muscles of the face or neck at night or first thing in the morning? _____ Please describe _____
- N. Do you have pain in the shoulders? _____
- O. Do you have pain in the lower back? _____
- P. Do you have pain in the muscles of the top of your neck or back of the head? _____
- Q. Describe your head position? Back, forward, left or right? _____
- R. Describe your shoulder position? Pointing forward, relaxed and down etc. _____

Pain Symptoms:

1. Do you have pain in the right TMJ joint? _____ Left TMJ joint? _____
2. When did the symptoms start? _____
3. Is the pain constant or intermittent? _____
4. How often do you have pain? _____
5. Does the Pain start abruptly? _____ Gradually? _____
6. What time of the day or night is pain most severe? _____
7. What is the longest period you have gone without pain? _____
8. What medications, if any, do you take to relieve the pain? _____
9. Please describe any method of positioning the jaw that you have found for relieving pain? _____
10. Do any of the following normal daily activities cause pain?
Yawning? _____ Chewing? _____ Swallowing? _____ Speaking? _____
Brushing Teeth? _____ Turning Head? _____ Moving your Shoulders? _____
11. Do your teeth hurt? _____
Irregular or raised dental fillings? _____ Excessive opening of mouth during a dental extraction? _____
Previous orthodontic treatment using head gear? _____ Traction for cervical arthritis? _____

Sleeping Patterns:

Please answer "Yes" or "No" and brief description.

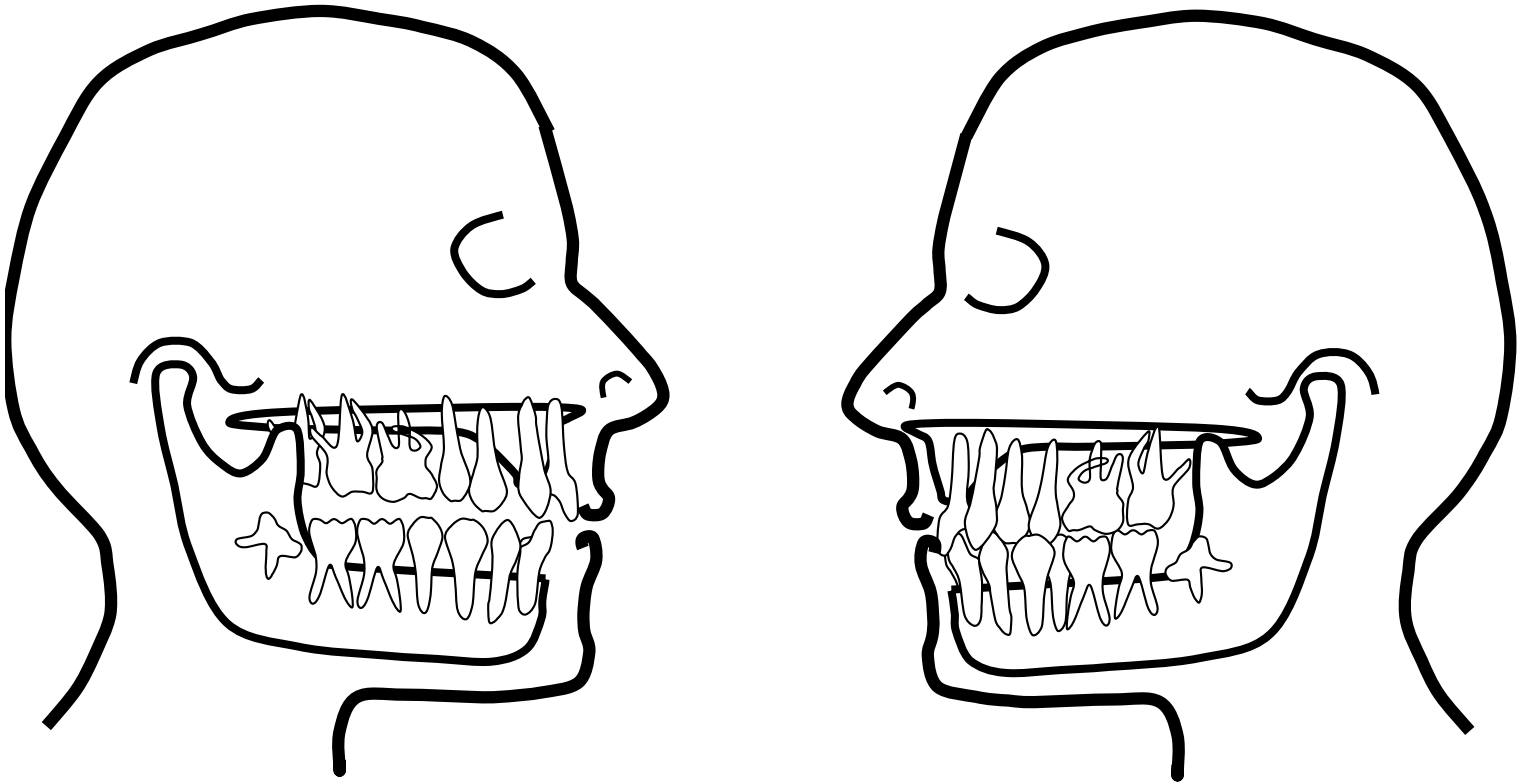
12. Do you get little or no sleep? _____
13. Do you fear bed time? _____
14. Do you wake-up in pain? _____
Describe any pain or soreness from the head or neck during sleeping or just after waking up. _____

15. Do you snore? _____
16. Do you grind or clench your teeth? _____
17. Are your jaws clenched when you awaken from sleep? _____
18. Are your jaw muscles ever tired? _____ When? _____
19. Do you ever feel pressure or tenderness about the right eye? _____
Left eye? _____
20. Do you ever get dizzy? _____ How often? _____
21. Do you ever feel faint? _____
22. In which ear do you ever notice ringing? _____
Popping sounds? _____
Stiffness? _____
Pain? _____
A hearing change? _____
23. Is there a family history of temporomandibular joint dysfunction? _____
24. If you have been treated for TMJ Dysfunction, did any of the treatment help you? _____
25. Did any of the treatment make you feel worse? Which ones? In what manner? _____

Please check “Yes” or “No” to the following questions:

Yes No

- - Have lower wisdom teeth been removed?
- - Have you ever had orthodontic treatment?
- - Were teeth removed for orthodontic treatment?
- - Do you have dental crowns or a bridge?
- - Do you have missing back teeth and no replacement?
- - Have you ever been treated for problems of your jaw joint, or for facial muscle spasms?
- - Have you ever had surgery on your jaw joint/TMJ?
- - Do you have any pain or soreness around your eyes, ears or other parts of your face?
- - Do you have “tension” headaches?
- - Do you usually eat breakfast?
- - Do you have difficulty in opening your mouth widely?
- - Have you ever received a severe blow to the side of the head or jaw?
- - Does it cause pain to open your jaw widely?
- - Do you ever hear clicking or popping sounds from your jaw joint?
- - Are you presently in any pain from your jaw joint or muscles?
- - Does pain or discomfort from your jaw joint interfere with your work or other activities?
- - Are there times when you notice that this problem or pain is less or gone completely?
- - Do you feel you need treatment for this problem?
- - Do you take aspirin frequently?
- - Do you take NSAID frequently? Morin, advil or ibuprofen
- - Are you taking any tranquilizers, muscle relaxants, or anti-depressants?
- - Are you afraid your problem is serious?
- - Does your health problem allow you to collect disability income?



Clinical Descriptions: _____

