Williamsburg Oral and Maxillofacial Surgery 195 B Strawberry Plains Road Williamsburg, Va. 23188 (757) 229-6692

PATIENT INFORMATION ABOUT TMJ

The source of your problem may very well be a tiny joint located where the jaw meets the skull, the tempormandibular joint (or TMJ). If the TMJ is the slightest bit out of alignment, then something as common as everyday tension can cause the muscles around the TMJ to tighten. This can result not only in headache pain, but pain in other areas as well, including the jaw and ears, not to mention clicking and popping sounds when you open and close your mouth.

This information is designed to make your entry into this TMJ practice as smooth, educated and uncomplicated as possible. Dr. West chooses to approach this complicated field from a team approach, which means either prior to, or during your treatment, you may be asked to see other specialists, the reasons will be explained to you and the specialists will be contacted.

Because proper diagnosis is important for evaluation of the TMJ, the sequencing of your treatment, in most cases, is as follows:

1. Detailed History
2. Physical Examination
3. Diagnostic Studies
4. Specialist Consultation consisting of, but not limited to:
   a. Orthodontic Consultation
   b. Psychological Evaluation
   c. Physical Therapy Evaluation
   d. Dental Examination
   e. Neurology Consultation
   f. Rheumatology Consultation
5. Surgical Approach consisting of, but not limited to:
   a. TMJ Athroscopic Surgery
   b. TMJ Arthroplastic Surgery

The details of each of the above steps as you approach them will be explained and, of course, all of your questions answered. Time will be spent on detailed, informed consent and you will be asked to sign an operative permit. In most cases, treatment of TMJ disorders will be covered by major medical insurance. This office will assist you by pre-determining insurance coverage on all surgical cases. Surgical fees are given early in the treatment plan, enabling us to make financial arrangements with you in advance of the surgery. Our Patient Representative will spend time explaining your financial obligations to you.

Dr. West and his staff hope that this information has been helpful to you and we are looking forward to knowing you better as you progress through your treatment. The following TMJ Questionaire needs to be completed prior to meeting with Dr. West for your initial consultation.

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TMJ QUESTIONAIRE

Patient Name: ____________________________ DOB:______________
Referred by:_______________________ Todays Date: ______________
Describe your symptoms:____
____
____.
How long has this been present?__________________________________
Was there an event which you believe may have helped cause this?______
If yes, please describe: Accident/Trauma____________________
Dental Treatment______________ Surgery_________________
Stress_______________________ Other___________________
____

Is the pain CONSTANT OR INTERMITTENT? (circle one)
Does it hurt to move your jaw? Yes No To Chew? Yes No
Does the problem limit your function? Yes No
If yes, how?____
When is the pain worse? Morning Afternoon Evening
Does anything you do make the pain worse?_________________________
Does anything you do make the pain better?_________________________
What other doctors or health care associates have you seen regarding this problem? ____
Indicate any type of treatment have you had for this problem:
Medications:_______________________ Orthotics:___________________
____
Orthodontics:_________________
Physical Therapy:___________________ Surgery:_____________________
Occlusal Adjustment:________________ Counseling:__________________
Splints:___________ How many?______ Other:_______________________
Does your jaw/joint make noise? Yes No When?_________________
If yes, for how long?___________
Does your jaw ever lock? Yes No In which position? Open Closed
How has this been treated?_______________________________________
Can you do anything to prevent or treat this?_________________________
Do you grind your teeth?____

Do you have or have you had any of the following? (place a check mark)

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____	Home Stress____

List other medical problems:_______________________________________
____.

On the scale below mark where your pain falls:
Most of the time with a line (/)
At its worse with a circle (o)
At its best or least with an (x)

0 25 50 75 100
l------------------l------------------l------------------l--------------------l
no pain — worst pain imaginable

The pain is having this effect on my life:

0 25 50 75 100
l------------------l------------------l------------------l--------------------l

0	25	50	75	100
no effect	slight effect I can work/play but aware of the pain.	moderate effect Some days I can't function	severe effect Most days I can't function	cannot function at all

Please draw an outline on the area of your pain on the diagram below: