6011 Morriss Rd.Suite 200
Flower Mound, TX 74028
(972) 874-3957

TMJ/TMD Treatment Questionnaire

PATIENT INFORMATION

Patient Name: ________________________ Date of Birth ___/___/_____
Chief Complaint: ____

MEDICATIONS (Including prescription and over-the-counter)

1. __________________________ 5. ___________________________
2. __________________________ 6.____________________________
3. __________________________ 7.____________________________
4. __________________________ 8.____________________________

Do you have any allergies to any medications?☐ Yes☐ No
If yes, please list:

____

____

PAST TMJ HISTORY

1.__________________________ 5. ___________________________
2.__________________________ 6.____________________________
3. __________________________ 7.____________________________
4. __________________________ 8.____________________________

Have you ever had your tonsils and/or adenoids surgically removed?
☐ Yes☐ No

Please download this form and save to your computer prior to filling out. Once you've completed this form, please email to: maryanne@drhalstewart.com. We look forward to treating you!