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TMJ PROBLEM QUESTIONNAIRE

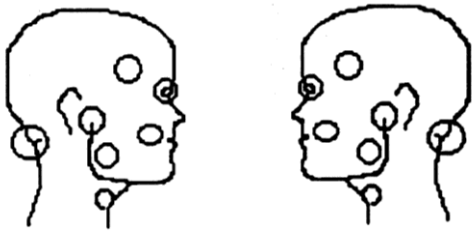
PLEASE ANSWER ALL QUESTIONS | **DO NOT WRITE IN THIS SPACE**

I. Name:_____ Date:_____
DOB: _____ Age: _____

II. Do you have headaches? _____
Neck pain? _____ Jaw pain? _____
Ear pain? _____ Facial pain?_____
Other? _____

Which side hurts?
Right _____ Left _____ Both _____

III. Place an (X) in the circle where you hurt.



RIGHT SIDE LEFT SIDE

IV. How long have you had this pain? _____

Is the pain constant? _____
Would you describe the pain as:
Aching? _____ Burning? _____ Stabbing? _____
Other? _____

V. Is the pain worse in the:
Morning? _____ Afternoon? _____
Awake? _____ Sleeping? _____

VI. Have you ever injured or sustained any form of trauma or whiplash to your:
Jaw? _____ Head? _____ Neck? _____
(If so, please complete the trauma questionnaire)

VII. What makes the pain worse?_____
_____
What makes the pain better? _____
_____

TMJ PROBLEM QUESTIONNAIRE PAGE 2

PATIENT NAME: | **DO NOT WRITE IN THIS SPACE**

What medication do you take or have you taken previously for your pain?

Medication	**Dose**	**Frequency**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VIII. Does it hurt to chew? _____ Open wide? _____
Which side of jaw makes a popping noise? _____
Clicking? _____ Grinding? _____
Other noise? _____
When did you first notice jaw joint sounds? _____
_____

IX. Has your jaw ever locked? _____
Open position? _____ Closed position? _____

When did this first happen? _____
Last happen? _____

Has your jaw ever slipped out of place? _____
Which side? _____

X. Have you noticed a change in your bite? _____
Front teeth? _____ Back teeth? _____
Has your profile changed? _____

Have you noticed any crookedness or asymmetry of your face or jaw? _____ When? _____

XI. Are your teeth sore or sensitive? _____
Do you clench your teeth? _____ Grind? _____
During the day? _____ At night? _____
When did you start doing this? _____

XII. Do you have problems with your ears? _____
Dizziness? _____ Ringing? _____
Hearing? _____ Other? _____

XIII. Is it difficult to swallow? _____
Painful to swallow? _____

Have you noticed any lumps in your:
Face? _____ Throat? _____ Neck? _____
Other? _____

TMJ PROBLEM QUESTIONNAIRE PAGE 3

PATIENT NAME: | **DO NOT WRITE IN THIS SPACE**

XIV. Have you had any prior treatment for this problem? _____

_____

Splint? _____ When? _____ Did it help?____

Nightguard? _____ When? _____ Did it help?____

Bite adjustment?_____ When? _____ Did it help?____

Orthodontics? _____ When? _____ Did it help?____

Other? _____

_____

XV. Describe the problems in your own words as you understand them.

_____

_____

_____

_____

_____

_____

_____

_____

XVI. Reports may be sent to my: (Name)

Medical Doctor _____

Dentist _____

XVII. I have completed the above to the best of my knowledge and I personally have filled out each blank in my own handwriting. I consent to the use of my x-rays, records, and photos for scientific publication or teaching providing my name remains anonymous.

_____

Signature

_____

Date