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TMJ PATIENT QUESTIONNAIRE

NAME _____ DATE _____
REFERRED BY _____

1) What is your main reason for being here today? _____
2) Do you have clicking, popping, or grating noise in your right jaw joint? Yes ___ No ___
in your left jaw joint? Yes ___ No ___
A) When did you first notice the noise? _____
B) Has the noise recently become more pronounced? **Yes** ___ **No** ___
When? _____
C) Has the noise ever disappeared? **Yes** ___ **No** ___
When? _____
3) Do you have pain in or around the right joint? **Yes** ___ **No** ___
the left joint? **Yes** ___ **No** ___
A) When did you first notice the pain? _____
B) Has the pain recently become more pronounced? **Yes** ___ **No** ___
When? _____
C) Is the pain worse: Mornings _____ At meals _____
Evenings _____ No specific time _____
D) Is the pain: Dull _____ Continuous _____
Stabbing _____ Intermittent _____
Throbbing _____ Other _____
E) Does the pain sometimes feel like it is in your ears? **Yes** ___ **No** ___
4) Do you think this problem has affected your hearing? **Yes** ___ **No** ___
5) Does your jaw problem interfere with your normal activities? **Yes** ___ **No** ___
6) Are you taking or have you taken medication for this problem? **Yes** ___ **No** ___
Explain _____
7) Do you have frequent headaches or neckaches? **Yes** ___ **No** ___
What area? _____
How frequent? _____
How do you control the pain? _____
8) Have you ever had a severe blow or trauma to the head, neck, or jaw? **Yes** ___ **No** ___
Which area? _____
Explain _____
9) Do you have difficulty chewing? **Yes** ___ **No** ___
Because of: Pain in joint _____ Limited opening _____
Pain in teeth _____ Missing teeth _____
Clicking _____ Other _____

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10) Has your mouth ever locked open so that you were unable to close it? **Yes**__ **No**__
Explain _____

11) Has your mouth ever locked closed? **Yes**__ **No**__
Explain _____

12) Do you experience ringing or other sounds in the ears? **Yes**__ **No**__
Explain _____

13) Which aspects of your problem concern you the most? _____

_____

14) Are you aware of clenching your teeth? **Yes**__ **No**__
When? _____

15) Do you grind your teeth? **Yes**__ **No**__
When? _____

16) Do you think nervous tension seems to affect this problem? **Yes**__ **No**__
Explain _____

17) Have you had problems with other joints? **Yes**__ **No**__
Explain _____

18) Have you had orthodontic treatment? **Yes**__ **No**__
When? _____ Doctor's name _____

19) Have you had recent dental treatment? **Yes**__ **No**__
When? _____ Doctor's name _____
Explain _____

20) Have you had x-rays taken for this problem? **Yes**__ **No**__
When? _____

21) Have you received previous treatment for this problem? **Yes**__ **No**__
When? _____ By whom? _____
Explain _____

22) Is there any litigation (past or future) associated with this problem? **Yes**__ **No**__
Explain _____

_____

_____

23) Do you have any allergies? **Yes**__ **No**__
Environmental (such as foods, animals, plants, chemicals) _____

_____

Medical (such as drugs, anesthetics, iodine - IVP dye) _____

_____

24) Have you ever had a reaction to medication other than allergic in nature? **Yes**__ **No**__
If yes, explain _____

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25) Have you ever been treated for any mental or emotional problems? **Yes**__ **No**__
If yes, please explain with dates _____

_____

_____

26) Do you suffer from stomach troubles or ulcer problems? **Yes**__ **No**__
27) Are you suffering from rheumatism or arthritis? **Yes**__ **No**__
What kind? Rheumatoid__ Degenerative__ Traumatic__ Gout__ Other _____
28) Do your muscles and joints ever feel stiff or swollen? **Yes**__ **No**__
29) Do you ever experience muscle aches or spasms? **Yes**__ **No**__
If yes, where? _____
30) Do you have trouble sleeping? **Yes**__ **No**__
Do you use sleeping pills? **Yes**__ **No**__
31) Do you suffer from low back pain? **Yes**__ **No**__
32) Do your salivary glands ever hurt or swell? **Yes**__ **No**__
33) Have you ever had dental pain or infection? **Yes**__ **No**__
Explain _____
34) Have you had your wisdom teeth removed? **Yes**__ **No**__
35) Do you have any eye problems? **Yes**__ **No**__
Do you wear glasses, contact lenses? **Yes**__ **No**__
Blurred vision? **Yes**__ **No**__
Double vision? **Yes**__ **No**__
"Spots"? **Yes**__ **No**__
Pain behind the eye(s)? **Yes**__ **No**__
Eye surgery? **Yes**__ **No**__
36) Do you have sinus problems? **Yes**__ **No**__
37) Does it hurt to open wide? **Yes**__ **No**__
38) Do you chew exclusively on one side? **Yes**__ **No**__
39) Does your bite feel uncomfortable? **Yes**__ **No**__
40) Are you currently under extra stress? **Yes**__ **No**__
At home? Explain _____

_____

_____

At work? Explain _____

_____

_____

41) Social history:
a) Employment _____

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b) Marital status _____

c) Children? Yes ____ Ages _____

d) Use of tobbaco/alcohol _____

e) Use of Aspirin, Tylenol, etc _____ Tablets/Day ____

f) Other life stress situations _____

_____

_____

_____

42) Habits: Frequency

a) Chew gum?	Yes__	No__	_____
b) Chew tobacco?	Yes__	No__	_____
c) Bite on foreign objects:	Yes__	No__	_____
Pens	Yes__	No__	_____
Pencils	Yes__	No__	_____
Pipe	Yes__	No__	_____
Fingernails	Yes__	No__	_____
Other_____	Yes__	No__	_____
d) Cradle the telephone in between neck & shoulder?			
Right	Yes__	No__	_____
Left	Yes__	No__	_____
e) Rest chin in palm?			
Right	Yes__	No__	_____
Left	Yes__	No__	_____
f) Sleeping posture:			
On stomach with head to right	Yes__	No__	_____
On stomach with head to left	Yes__	No__	_____
On back with head too high	Yes__	No__	_____
On side with head too high	Yes__	No__	_____
On right side	Yes__	No__	_____
On left side	Yes__	No__	_____

Please mark areas of muscle tenderness with an X and circle the most severe