

Welcome to Our Office!

Please help us get acquainted by filling out the following important information.

QUESTIONNAIRE FOR PATIENTS WITH TEMPORO-MANDIBULAR JOINT (TMJ) DYSFUNCTION

Patient _____ Age _____ Occupation _____ Date _____
Address _____
_____ Zip _____ Phone (_____) _____

Others who are or have been treating this problem:

Doctor: _____
Address: _____
Doctor: _____
Address: _____

GENERAL SYMPTOMS

1. When did you first notice this condition? _____
Describe changes since then: _____
2. Your problem is in your: ear jaw jaw-joint teeth face neck eye back of head
other: _____
3. Is it located in the right left or both sides
4. Do you feel any difference between the two sides? yes no
Describe: _____
5. Would you call your problem: simple concern suffering other _____
Describe: _____
6. Does it hurt or is it just uncomfortable or . . . _____
7. yes no Does the pain or discomfort disturb your sleep?
8. yes no Does the pain or discomfort interfere with daily activities? How? _____
9. yes no Is there constant or recurring pain: Right Left Where: _____
10. yes no Burning pain: Right Left Where: _____
11. yes no Dull, aching pain: Right Left Where: _____
12. yes no Stabbing severe pain: Right Left Where: _____
13. yes no Can you locate a specific site of pain: Right Left Where: _____
14. yes no Does it hurt when you chew? Where: _____
15. yes no Does it hurt to open wide or to take a big bite?
16. yes no Does your jaw make "clicking or popping" sounds when you chew? Right Left
17. yes no Does your jaw "feel tired" after a big meal? Right Left
18. yes no Do you have ear pain? When: _____ Where: _____
19. yes no Do you have pain in front of the ears? When: _____
20. yes no Do you have pain in the face, jaws, eyes, throat, neck or temple region? Describe: _____
21. yes no Do you suffer from chronic headaches? When: _____
Where: _____
22. yes no Is the condition worse in the morning during the day evening during sleeping
 after eating after speaking
23. yes no Do you prefer one side in chewing? Which side? _____
24. yes no Do you chew exclusively on one side? Which side? _____
25. yes no Has anyone heard you grinding in your sleep? During day? yes no
When: _____ How often: _____
26. yes no Are you aware that you clench your teeth during the day? During night? yes no
When: _____ How often: _____
27. yes no Have you ever had chronic neck, shoulder, or back pain?
How long: _____ Where: _____
28. yes no Do you notice any of the following:

<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Stiffness in the ears	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Pain in teeth on arising	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Headaches	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Throbbing in ears	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Popping, clicking or grating sounds in the jaw	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Difficult to swallow	<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY

1. yes no Have you had a psychological evaluation or treatment? Describe: _____
2. yes no Are you under stress? mild moderate severe
3. yes no Have you ever had general anesthesia? When: _____
4. yes no Was there ever an accident or blow to jaw area? When: _____
Describe: _____
5. yes no Have you ever had a whiplash? When: _____
Any Treatment: _____
6. yes no Was there a strain or stretching of the jaw such as yawning, during a dental procedure, while chewing or opening the mouth wide? Describe: _____
7. yes no Have you ever had "ulcers" or similar disorders?
If so, describe: _____
8. yes no Have you ever had a digestive problem or colitis?
If so, describe: _____
9. yes no Do you have pain in the Abdomen? Hot flashes? Night sweats Trouble in breathing?
Are you frequently nauseated? yes no If so, when: _____
10. yes no Relative to these conditions, have you consulted another Specialist? _____
If so, what was the nature of treatment; _____
Under medical treatment now for: _____
11. yes no Do you take medication for the pain? If so, what? _____
How often _____ How much _____
12. yes no Have you recently had a Cold? Throat infection? Tooth infection
13. yes no Do you have high blood pressure? Your most recent blood pressure was _____
Taking medication: _____
14. yes no **Females Only:** Taking Birth Control Pills? Type _____
Taking Hormone or Glandular medications? yes no Type _____
Do you have headaches with menstruation? yes no With menopause? yes no

DENTAL HISTORY

1. yes no Are any of your teeth worn badly very loose sore
2. yes no Have you had any permanent teeth extracted? When: _____
3. yes no Have you had recent fillings? Recent crowns/bridges
 Other _____
4. yes no Have you worn braces or had your teeth straightened? If so, when: _____
By whom: _____
5. When were your last dental x-rays: _____ By whom: _____

CONCLUDING QUESTIONS

1. What does this problem keep you from doing? _____

2. Other pertinent Comments you wish to add: _____

3. Describe your diet:
 - a. Breakfast _____
 - b. Lunch _____
 - c. Dinner _____
 - d. Snacks/other _____
 - e. Vitamins, minerals, other _____

I give my permission for Dr. _____ to release any information from my diagnostic records.

Signature _____ Date _____

FOR DOCTORS USE


