

## TMJ HEALTH QUESTIONNAIRE

CHIEF CONCERN \_\_\_\_\_

DATE OF ONSET \_\_\_\_\_

### PAIN SYMPTOMS

Do you get "tension headaches"? Y N  
 Do you ever get "migraine headaches" Y N  
 Do you frequently have neck aches or stiff neck muscles Y N  
 Do you have trouble sleeping soundly? Y N  
 Have your teeth been sore upon waking? Y N  
 Does your jaw ache when you chew? Y N  
 Do you have ear pain? Y N  
 Does your jaw ache when you open wide? Y N  
 Have you ever had chronic shoulder or back pain? Y N  
 What medications, if any, are you taking?  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you get headaches in the right or left temple areas? Y N  
 Do you get headaches in the back of your head? Y N  
 Do you grind your teeth when asleep? Y N  
 Are your jaws tired when you awaken from sleep? Y N  
 When are your symptoms the worse? \_\_\_\_\_  
 \_\_\_\_\_  
 Does anything make you feel better? \_\_\_\_\_  
 \_\_\_\_\_

Have your wisdom teeth been extracted? Y N  
 Details \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How often do you take medicine for relief of pain?

- a) Never                      b) Weekly to Monthly  
 c) Weekly                     d) Daily

### TRAUMA OR ACCIDENTS

Have you ever had a serious blow to the head or jaw? Y N  
 Any whiplash neck injuries Y N

Have you ever been involved in any serious accidents, such as a car accident? Y N  
 Details \_\_\_\_\_  
 \_\_\_\_\_

### JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N  
 Are there any foods you avoid eating Y N  
 Do you ever get dizzy? Y N  
 Do you ever faint? Y N  
 Do you feel nauseated (sick)? Y N  
 Is there a family history of jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a "clicking", "popping", or "cracking" noise from either jaw joint? Y N  
 Has your jaw ever locked where you were unable to open or close? Y N  
 Do you have difficulty opening wide or yawning? Y N  
 Have you ever had pain in either jaw joint? Y N

### EAR AND EYE SYMPTOMS

Do you have itchiness or stiffness in either ear? Y N  
 Do you suffer from any loss of hearing? Y N  
 Do you get pain in, around or behind either eye? Y N

Are there times when your eyesight blurs? Y N  
 Do you hear ringing, buzzing, or hissing sounds in either ear? Y N  
 Do you hear grating noises in ears (like sand particles rubbing?) Y N  
 Do you wear glasses or contacts? Y N

### BREATHING

Do you have allergies? Y N  
 Do you have sinus problems? Y N  
 Do you snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N

## Occlusal Signs and Symptoms

Please indicate the complaints you regularly or occasionally have.

	Right	Left		Right	Left
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Headache	<input type="checkbox"/>	<input type="checkbox"/>
Cluster Headache	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joint – biting	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Jaw Joint – opening	<input type="checkbox"/>	<input type="checkbox"/>	Pain around Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain in upper jaw	<input type="checkbox"/>	<input type="checkbox"/>	Tearing of Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain in lower jaw	<input type="checkbox"/>	<input type="checkbox"/>	Pressure behind Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Cheek Muscles	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Temples	<input type="checkbox"/>	<input type="checkbox"/>	Ringling or noises in Ear	<input type="checkbox"/>	<input type="checkbox"/>
Locked Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ear	<input type="checkbox"/>	<input type="checkbox"/>
Limited Jaw Opening	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness in Ear	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the neck	<input type="checkbox"/>	<input type="checkbox"/>	Click, snap or pop in Ear	<input type="checkbox"/>	<input type="checkbox"/>
Pain in the shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Grating Sound in Ear	<input type="checkbox"/>	<input type="checkbox"/>
Neck ache	<input type="checkbox"/>	<input type="checkbox"/>	Itchy Ear	<input type="checkbox"/>	<input type="checkbox"/>
Pain in Forehead	<input type="checkbox"/>	<input type="checkbox"/>	Arm, Finger numbness	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>

List Treatments for this problem you have had.

**DOCTOR**

**TREATMENT**

- |    |  |
|----|--|
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

Have you ever had cortisone or any other drug injected into your jaw joint?

Y      N

Do you attribute your problem to any one incident?

Y      N

Is your skin sensitive to metal, finger rings or ear rings?

Y      N

Have you had your bite adjusted by your dentist?

Y      N

Have you had your wisdom teeth removed?

Y      N

Have you had a complete mouth rehabilitation by your dentist or other extensive dental treatment?

Y      N

Do you wear and orthodontic or dental appliance in your mouth? Y      N

Are your symptoms worse:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
When you get up in the morning	<input type="checkbox"/>	<input type="checkbox"/>	When with children	<input type="checkbox"/>	<input type="checkbox"/>
At the end of your work day	<input type="checkbox"/>	<input type="checkbox"/>	When under stress	<input type="checkbox"/>	<input type="checkbox"/>
At bedtime	<input type="checkbox"/>	<input type="checkbox"/>	When eating	<input type="checkbox"/>	<input type="checkbox"/>
At work	<input type="checkbox"/>	<input type="checkbox"/>			

Date: \_\_\_\_\_

Signature \_\_\_\_\_