TMJ HEALTH QUESTIONNAIRE

CHIEF COMPLAINT ______________________________

DO YOU FEEL THE NEED FOR TREATMENT? ☐ Y ☐ N

DATE OF ONSET ______________

PAIN SYMPTOMS

Do you get "tension headaches"? Y ☐ N ☐

Do you ever get "migraine headaches"? Y ☐ N ☐

Do you frequently have neckaches or stiff neck muscles? Y ☐ N ☐

Do you have trouble sleeping soundly? Y ☐ N ☐

Have your teeth been sore upon awakening? 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 ☐

Do you get headaches in 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 makes you feel better?______________________

____

How often do you take medicine for relief of pain?
a. Never b. Weekly to Monthly
c. Weekly d. Daily

What medication, if any, are you taking? ______________________

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TRAUMA OR ACCIDENTS

Have you ever had a severe 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 ______________________________

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JAW JOINT SYMPTOMS

Does your jaw feel tired after eating a big meal? Y ☐ N ☐

Are there any food you avoid eating? Y ☐ N ☐

Do you ever get dizzy? Y ☐ N ☐

Do you ever feel faint? Y ☐ N ☐

Do you ever feel nauseated (sick) Y ☐ N ☐

Do you feel or heard a "clicking", "popping" or "cracking" noise from either jaw point? Y ☐ N ☐

Has you 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 point? Y ☐ N ☐

Is there a family history of jaw point (TMJ) problems or headaches? Y ☐ N ☐

EAR AND EYE SYMPTOMS

Do you have itchiness or stuffiness 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 have any pain in ears? 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 ☐

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

Do you snore at night? Y ☐ N ☐