



ATLANTA ORAL & FACIAL SURGERY

Comprehensive Oral & Maxillofacial Surgery

TMJ QUESTIONNAIRE

Patient Name _____ Date: _____

CHIEF COMPLAINT:

- What is the main problem that brings you here? _____

- Did this problem begin: **SUDDENLY** **GRADUALLY**
- How long have you been bothered by this problem? **YEARS** **MONTHS** **WEEKS** **DAYS**

PAIN SYMPTOMS:

- Location (please circle all locations that you are having pain. Circle **R** for right, **L** for left)

Joint	R	L
Ear	R	L
Upper teeth/jaw	R	L
Lower teeth/jaw	R	L
Eyes	R	L
Face	R	L
Shoulders	R	L
Forehead	R	L
Neck	R	L

- Headaches (answer only if you have regular headaches)

How often? _____

Time of Day _____

Location: **ONE SIDE** **BOTH SIDES**

Previous Diagnosis and Treatment: _____

- Circle all the terms that describe your pain:

SHARP DULL ACHING DEEP SUPERFICIAL BURNING PULSING SPREADING

- Rate your pain today by placing a line on the following scale:

NONE

WORST

0-----100

- Is this pain: **CONSTANT** **INTERMITTENT**
- Does the pain last for: **MINUTES** **HOURS**
- Does the pain start: **SUDDENLY** **GRADUALLY**

- Does the pain stop: **SUDDENLY** **GRADUALLY**
- What time of the day is the pain most severe? _____
- What is the longest period of time you have gone with pain? _____
- What medication, if any, do you take for pain? _____
- Does rest increase or decrease the pain? _____
- Does positioning your head or jaw in a certain position relieve pain? **YES** **NO**
Briefly describe: _____
- Do any normal activities cause pain? **YES** **NO**
Briefly describe: _____

DYSFUNCTION:

- Can you open your mouth: **NORMALLY** **PARTIALLY** **VERY LIMITED**
- Has your jaw ever locked open or shut: **YES** **NO**
- Do you have any of these sounds in your jaw joints?

GRATING:	R	L	CLICKING:	R	L
SNAPPING:	R	L	POPPING:	R	L
- If you have any of these problems, is it: **FREQUENTLY** **OCCASIONALLY** **CONSTANTLY**
- Have you noticed any change in your bite or ability to chew? **YES** **NO**

OTHER COMPLAINTS & QUESTIONS:

- Do you have problems with your ears? **YES** **NO**
If yes, are the problems: **PAIN** **DIZZINESS** **RINGING** **OTHER:** _____
- Are your jaws clenched or teeth sore when you awaken from sleep? **YES** **NO**
- Do you grind or clench your teeth? **YES** **NO**
- Do you chew gum? **YES** **NO**
- Are your muscles ever tired? **YES** **NO**
- Have you had orthodontic treatment (braces)? **YES** **NO**
- Have you ever had your bite adjusted by your dentist? **YES** **NO**
- Do you play a musical instrument? **YES** **NO**

Please list any other pertinent information you feel we should know: _____

Have you been treated previously for this problem? _____

By Whom: _____ Telephone: _____

Diagnosis & Treatment: _____
