



# 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)

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

- 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?  

<b>GRATING:</b>	<b>R</b>	<b>L</b>	<b>CLICKING:</b>	<b>R</b>	<b>L</b>
<b>SNAPPING:</b>	<b>R</b>	<b>L</b>	<b>POPPING:</b>	<b>R</b>	<b>L</b>
- 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 or ice? **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 or sing? **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: \_\_\_\_\_  
 \_\_\_\_\_