ATLANTA
ORAL & FACIAL
SURGERY

TMJ Questionnaire

Patient Name: ______________________________ Date: ____________________________

CHIEF COMPLAINT

- What is the main problem that brings you here? _____________________________
  ____
- Does 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**
- Does the pain stop: **SUDDENLY** **GRADUALLY**

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- 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 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: ____

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