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TMJ Health Questionnaire

Name: _____ Date: _____
Chief Complaint: _____
Date of Onset: _____

PAIN SYMPTOMS

Do you get headaches?	Y	N
Do you get headaches in right temple?	Y	N
Do you get headaches in left temple?	Y	N
Do you get migraine headaches?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N
Do you get headaches in the front of your head?	Y	N
Do you get headaches in the back of your head?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N
Do you have trouble sleeping soundly?	Y	N
Are your jaws tired when you awaken?	Y	N
Have your wisdom teeth been extracted?	Y	N
Do you clench your teeth during the day?	Y	N
Do you clench your teeth during the night?	Y	N
Do you grind your teeth when asleep?	Y	N

When are your symptoms worse? _____
Does anything make you feel better? _____
_____
How often do you take medication for pain relief? _____
What medication(s), if any, are you taking? _____
_____

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 I any serious car accidents?	Y	N

If yes, please provide 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 feel faint?	Y	N
Do you ever feel nauseated (sick)?	Y	N
Is there family history of TMJ or headaches?	Y	N
Do you feel or hear a “clicking” or “popping” from either joint?	Y	N
Has your jaw ever locked and 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
Does your jaw ache after you open wide?	Y	N

EAR AND EYE SYMPTOMS

Do you have any pain in your ears?	Y	N
Do you suffer from any loss of hearing?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N
Do you hear ringing, buzzing, or hissing in either ear?	Y	N
Do you wear contacts or glasses?	Y	N
Are there times when your eyesight blurs?	Y	N
Do you get pain in, around or behind either eye?	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
Have you been diagnosed with Sleep Apnea?	Y	N
Have you had a sleep study done at a sleep clinic (hospital)?	Y	N