Patient Name: [ ] [ ] [ ] [ ]
Last First MI Preferred Name

Temporomandibular Joint (TMJ) Questionnaire

Chief Complaint:

Pain Symptoms:

1. Do symptoms affect one or both joints?

☐ Right ☐ Left ☐ Both

1a. *If both joints, which is most affected?

○ Right ○ Left

2. What symptoms do you have

☐ Pain in joint - right	☐ Pain in joint - left
☐ Pain in ear - right	☐ Pain in ear - left
☐ Pain around eyes - right	☐ Pain around eyes - left
☐ Pain in upper jaw - right	☐ Pain in upper jaw - left
☐ Pain in neck - right	☐ Pain in neck - left
☐ Pain in forehead - right	☐ Pain in forehead - left
☐ Pain in facial area - right	☐ Pain in facial area - left
☐ Grating sound in joint - right	☐ Grating sound in joint - left
☐ Subjective hearing loss - right	☐ Subjective hearing loss - left
☐ Dizziness (vertigo) - right	☐ Dizziness (vertigo) - left
☐ Ringing in ears (tinnitus) - right	☐ Ringing in ears (tinnitus) - left
☐ Headache - right	☐ Headache - left
☐ Fullness, pressure blockage in ear - right	☐ Fullness, pressure blockage in ear - left
☐ Partial inability to open mouth - Constant	☐ Partial inability to open mouth - Sporadic

3. Other symptoms, please describe:

4. Check the kinds of pain you have

☐ Sharp ☐ Dull ☐ Aching ☐ Deep ☐ Superficial
☐ Burning ☐ Pulsating ☐ Spreading

5. Is the pain:

☐ Constant ☐ Intermittent

6. How long does the pain last?

☐ Moment ☐ Minutes ☐ Hours ☐ All Day

7. Does the pain start:

○ Suddenly ○ Gradually

8. Does the pain stop:

○ Suddenly ○ Gradually

9. What time of the day or night is the pain most severe?

10. How often do you have pain?

11. What is the longest period you have gone without pain?

12. What medication(s), if any, do you take to relieve the pain?

13. Does rest increase or decrease the pain?

14. Please describe any method of positioning the jaw or head tha tyou ahve found for relieving the pain

15. Do any of the following normal daily activities cause pain?

- [ ] Yawning
- [ ] Chewing
- [ ] Swallowing
- [ ] Speaking
- [ ] Singing
- [ ] Shouting
- [ ] Brushing
- [ ] Moving head
- [ ] Moving neck
- [ ] Moving Shoulders

15a. *If yes, indicate where you feel pain:

16. Do you ever open so wide your mouth locks open?

◯ Yes ◯ No

17. Do you have any of these sounds in the joint: grating, snapping, clicking, popping?

- [ ] Grating - right
- [ ] Grating - left
- [ ] Snapping - right
- [ ] Snapping - left
- [ ] Clicking - right
- [ ] Clicking - left
- [ ] Popping - right
- [ ] Popping - left

Miscellaneous and Associated Complaints and Questions

1. Are your jaw muscles ever tired? If so, when?

2. Do you have a jaw thrust habit or nervous twitch about the face (tick)? If yes, where and when?

3. Does your face swell? If yes, what part?

4. Do you feel your pain is stress related?

◯ Yes ◯ No

5. Did the symptoms start after any of the following conditions? (check all that apply)

- [ ] Severe emotional upset
- [ ] A blow on the jaw
- [ ] Excessively large bite or yawn
- [ ] Traction for cervical whiplash
- [ ] Traction for cervical arthritis

6. How long have you been bothered by this problem?

7. Have you had any injury to the jaw for face? If yes, explain:

8. Do you have arthritis?

( ) Yes ( ) No

9. Have you had any other treatment for this problem? If yes, please explain: medicine, exercise, dental treatment etc)

10. Have you had your teeth straightened (orthodontia?)

( ) Yes ( ) No

11. Have you had your bite adjusted by your dentist? If yes, please explain when.

12. Have you had any images taken of your jaw joint?

( ) Yes ( ) No

13. Have you had cortisone injected into the joint? If yes: when, how many injections, by whom?

14. Do you know if you clench your teeth?

( ) Yes ( ) No

15. Has anyone mentioned that you grind your teeth (brux) at night during sleep?

( ) Yes ( ) No

16. Do you chew gum?

◯ Frequently ◯ Moderately ◯ Infrequently ◯ Never

17. Is there anyone else in your family with a similar problem? If yes, please explain.

18. Please describe briefly any changes in location or character of symptoms since this problem began.

19. Please list chronologically names and types of doctors and their location, whom you have seen in the past for this or related problems.

20. Did any of the treatment make you feel better? If so, which helped the most? In what manner?

21. Did any of the treatments make you feel worse? Which ones? In what manner?

22. Please write in any other pertinent information that has not been covered previously.

Response Date: