Temporomandibular Disorders (TMD)

PATIENT QUESTIONNAIRE

(Please Print Legibly)

Patient Name: ______________________ Date: ______________________

Referred by: ______________________

Directions: Please answer all by checking, circling, or filling in the blank on all that apply.

YES	NO	
❏	❏	1. Do you have frequent headaches?
❏	❏	2. Do you have pain in or around the right jaw joint?
❏	❏	3. Do you have pain in or around the left jaw joint?
		4. When did you first notice the jaw pain? ______________________
❏	❏	5. Has the pain recently become more severe? If so, when? ______________________
		6. The pain is worse in the: Mornings Evenings At Meals No Specific Time
		7. The pain is: Dull Stabbing Throbbing Continuous Intermittent Other: ______________________
❏	❏	8. Does the pain sometimes feel like it is in your ear?
❏	❏	9. Do you have clicking, popping, or grating noise in your right jaw joint?
❏	❏	10. Do you have clicking, popping, or grating noise in your left jaw joint?
		11. When did you first notice the noise? ______________________
❏	❏	12. Has the noise become more pronounced recently?
❏	❏	13. Has your hearing worsened since your jaw problem began?
❏	❏	14. Does your jaw problem interfere with your normal activities?
❏	❏	15. Are you taking, or have you taken, medication for this condition? If so, what? ______________________ ______________________
❏	❏	16. Have you ever had a severe blow or trauma to the head, neck, or jaw? Explain: ______________________ ______________________ ______________________
❏	❏	17. Do you have difficulty chewing? If so, is this difficulty because of: ❏ pain in joint ❏ pain in teeth ❏ clicking ❏ limited opening ❏ missing teeth Other (specify): ______________________
❏	❏	18. Has your mouth ever locked open so you were unable to close it? If so, when? ______________________ ______________________
❏	❏	19. Have you had problems opening your mouth wide? If so, please explain: ______________________ ______________________

Temporomandibular Disorders (continued)

YES	NO	
❏	❏	20. Are you aware of clenching your teeth? When? ______
❏	❏	21. Do you grind your teeth? When? ______
❏	❏	22. Has there been recent change in your lifestyle such as, a change in marital status, childbirth, change of employment, death in immediate family, or other stressful events? If so, please explain: ______
❏	❏	23. Do you think nervous tension seems to affect this problem?
❏	❏	24. Have you had problems with other joints?
❏	❏	25. Have you had orthodontic treatment? If so, when? ______
❏	❏	26. Have you had recent dental treatment? If so, when? ______ Where? ______ Why? ______
❏	❏	27. Have you had recent x-rays taken for this problem? If so, when? ______ Where? ______