TMJ Problem Questionnaire

Name: _____ **Date**:_____

Describe your problem in your own words. (Use back if necessary)_____

_____

How long have you had these symptoms?_____

What makes the pain better?_____

What makes the pain worse?_____

What symptoms do you have? (Circle all that apply)

Tooth Pain Jaw Pain Headaches Joint Pain Muscle Pain
Ear Pain Eye Pain Neck Pain Other_____

Which side hurts? Left Right Both

Is the pain (Circle all that apply) Constant Off & On
Dull Sharp Shooting Burning Stabbing Electrical Other_____
Worst in the: Morning Afternoon Night

Does it hurt to: Chew Open Wide

Does (or did) your jaw ever make a noise: Clicking Popping Grating
Other Noise_____ Which side makes the noise?_____

Has your jaw ever: Locked Slipped out of place

Do you ever clench or grind your teeth? Y N
If so, when: During the day At night

Do you have problems with your ears? Y N
If so, does it involve: Hearing Dizziness Ringing Other_____

Is it difficult or painful to swallow? Y N

Are your teeth sensitive or sore? Y N

Have you ever had any injury or trauma to: Jaw Head Neck

Have you ever noticed a change in your bite? Y N
If yes, where? _____

Are you taking medicine of any kind? Y N
What for?_____

Have you had any prior treatment for this pain? Y N
If yes, circle all that apply: Splint Nightguard Bite adjustment
Orthodontics Surgery Other_____
Did any of these ever help? Y N
Explain_____