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QUESTIONNAIRE FOR PATIENTS WITH TEMPORO-MANDIBULAR JOINT (TMJ) DYSFUNCTION

Patient _____ Age _____ Occupation _____ Date _____
Address _____

Zip _____ Phone () _____

Referred by: _____ Phone () _____
Address _____ Zip _____

Others who are or have been treating this problem:
Doctor: _____
Address: _____
Doctor: _____
Address: _____

GENERAL SYMPTOMS

1. When did you first notice this condition? _____
Describe changes since then: _____
2. Your problem is in your: ear _____, jaw _____, jaw-joint _____, teeth _____, face _____, neck _____, eye _____, back of head _____, other _____
3. Is it located in the right _____, left _____, or both sides _____, neither _____
4. Do you feel any difference between the two sides? yes no
Describe: _____
5. Would you call it pain _____ simple concern _____ suffering _____ other (describe) _____
6. Does it hurt or is it just uncomfortable or? _____
Describe: _____
7. yes no Does the pain or discomfort disturb your sleep?
8. yes no Does the pain or discomfort interfere with daily activities?
9. yes no Is there constant or recurring pain Right Left Where _____
10. yes no Burning pain Right Left Where _____
11. yes no Dull, aching pain Right Left Where _____
12. yes no Stabbing, severe pain Right Left Where _____
13. yes no Can you locate a specific site of pain Right Left Where _____
14. yes no Does it hurt when you chew? Where? _____
15. yes no Does it hurt to open wide or take a big bite?
16. yes no Does your jaw make "clicking or popping" sounds when you chew? Right Left
17. yes no Does your jaw "feel tired" after a big meal? Right Left
18. yes no Do you have ear pain? When _____ Where _____
19. yes no Do you have pain in front of the ears? When _____
20. yes no Do you have pain in the face, jaws, eyes, throat, neck or temple region? Describe: _____
21. yes no Do you suffer from chronic headaches? When? _____
Where _____
22. yes no Is the condition worse in the morning _____, during the day _____, evening _____, during sleep-
ing _____, after eating _____, after speaking _____
23. yes no Do you prefer one side in chewing _____, which side _____
24. yes no Do you chew exclusively on one side? Which side? _____
25. yes no Has anyone heard you grinding in your sleep? yes no during day? yes no
When? _____ How often? _____
26. yes no Are you aware that you clench your teeth during the day? yes no during night? yes no
When? _____ How often? _____
27. yes no Have you ever had chronic neck, shoulder, or back pain?
How long? _____ Where? _____
28. yes no Do you notice any of the following:

Hearing loss _____	<input type="checkbox"/> Right <input type="checkbox"/> Left	Numbness _____	<input type="checkbox"/> Right <input type="checkbox"/> Left
Pain in teeth on arising _____	<input type="checkbox"/> Right <input type="checkbox"/> Left	Stiffness in ears _____	<input type="checkbox"/> Right <input type="checkbox"/> Left
Headaches _____	<input type="checkbox"/> Right <input type="checkbox"/> Left	Ringing in ears _____	<input type="checkbox"/> Right <input type="checkbox"/> Left
Neck pains _____	<input type="checkbox"/> Right <input type="checkbox"/> Left	Throbbing in ears _____	<input type="checkbox"/> Right <input type="checkbox"/> Left
Popping, clicking or		Tears in eyes _____	<input type="checkbox"/> Right <input type="checkbox"/> Left
grating sound in the jaw _____	<input type="checkbox"/> Right <input type="checkbox"/> Left	Dizziness _____	<input type="checkbox"/> yes <input type="checkbox"/> no
		Difficult to swallow _____	<input type="checkbox"/> yes <input type="checkbox"/> no

