Temporomandibular Joint Disorder (TMJ/TMD) Questionnaire

Date__________________
Name___________________________________________ Date of birth__________
Address________________________________________________________________
City, State, Zip______________________________
Who referred you to our office?______________________________________________

PAIN SYMPTOMS

1. Do symptoms affect one of both joints?  Right ( )  Left ( )  Both ( )
   (If both joints, also mark which joint seems most affected.)

2. What symptoms do you have (Please check appropriate areas: R= right, L= left.)
   a. Pain in joint
   b. Pain in ear
   c. Pain around eyes
   d. Pain in lower jaw
   e. Pain in upper jaw
   f. Pain in neck
   g. Pain in shoulder
   h. Pain in forehead
   i. Pain in facial area
   j. Grating sound in joint
   k. Subjective hearing loss
   l. Dizziness (vertigo)
   m. Upset stomach- nausea
   n. Ringing sound in ears (tinnitus)
   o. Headache
   p. Fullness, pressure blockage in ear
   q. Pain in tongue
   r. Total inability to open mouth
      Yes ( )  No ( )
      If yes, is it (1) Constant ( )  (2) Sporadic ( )
   s. Partial inability to open mouth
      Yes ( )  No ( )
      If yes, is it (1) Constant ( )  (2) Sporadic ( )
   t. Other symptoms (please write in): ______________________________________
   ________________________________________________________________
   ________________________________________________________________

______________________________________________________________
______________________________________________________________
u. Circle kinds of pain you have:
   Sharp  Dull  Aching  Deep  Superficial  Burning  Pulsating  Spreading
v. Is the pain constant? ( ) Intermittent? ( )
w. Does the pain last for a moment? ( ) Minutes? ( ) Hours? ( ) All day? ( )
x. Does the pain start suddenly? ( ) Gradually? ( )
y. Does the pain stop suddenly? ( ) Gradually? ( )
z. What time of the day or night is the pain most severe?____________

aa. How often do you have pain?______________________________________

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

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

dd. Does rest increase or decrease the pain?___________________________

e. Please describe any method of positioning the jaw or head that you have found
   for relieving pain__________________________________________________

ff. Do any of the following normal daily activities cause pain? If yes, indicate where
   you feel pain.

   Yawning       R ( ) L ( )  Brushing       R ( ) L ( )
   Chewing      R ( ) L ( )  Moving head   R ( ) L ( )
   Swallowing   R ( ) L ( )  Moving neck   R ( ) L ( )
   Speaking     R ( ) L ( )  Moving shoulders R ( ) L ( )
   Singing      R ( ) L ( )  Moving arms   R ( ) L ( )
   Shouting     R ( ) L ( )  Moving trunk  R ( ) L ( )

DYSFUNCTION

1. Can you open your mouth normally? ( ) Partially? ( ) Almost not at all? ( )
2. Do you ever open so wide your mouth locks open?  Yes ( ) No ( )
3. Do you have any of these sounds in the joint?
   Grating       R ( ) L ( )  Clicking       R ( ) L ( )
   Snapping     R ( ) L ( )  Popping        R ( ) L ( )
4. If you have any of these problems is it frequent? ( ) Occasional? ( )
5. Have you noticed any change in your bite? Yes ( ) No ( ) If yes, explain______________________________
MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS

1. Are your jaw muscles ever tired? Yes ( ) No ( ) If so, when? ______________

2. Do you have a jaw thrust habit or nervous twitch about the face (tic)?
   Yes ( ) No ( )
   Where? __________________________ When? ________________

3. Does your face swell? Yes ( ) No ( ) What part? __________________________
   When? ________________

4. Have you ever noticed production of more saliva or less saliva? __________

5. Do tears form in your eyes for no apparent reason? ________________

6. Did the symptoms start after any of the following conditions? (Check if yes)
   Severe emotional upset ( ) A blow on the jaw ( ) Excessively large bite or yawn
   ( ) Traction for cervical whiplash ( ) Traction for cervical arthritis ( )

7. How long have you been bothered by this problem? _______________________

8. Have you had any injury to the jaw or face? If yes, explain. ________________

9. Do you have arthritis? __________________

10. Have you ever had cervical traction? ______________

11. Have you had any other treatment for this problem? (If yes, explain-
    medicine, exercise, dental treatment) ________________________________

12. Have you had your teeth straightened (orthodontia)? ________________

13. Are you sensitive to metal rings or earrings? _________________________

14. Have you had your bit adjusted by your dentist? (If yes, please explain
    when) __________________________

15. Do you attribute the symptoms to any one incident? ________________

16. Have you had cortisone injected into the joint? If yes, when? __________
    How many injections? ____________ By Whom? ________________

17. Do you know if you clench your teeth? ____________________________

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

19. Do you chew gum? ( ) Frequently ( ) Moderately
    ( ) Infrequently ( ) Never
20. Is there anyone else in your family with a similar problem? (If yes, explain) ____________________________________________

21. Please describe briefly any changes in location or character of symptoms since this problem began________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

22. Please list chronologically names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on the back of the sheet if necessary, ____________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

23. Did any of the treatments make you feel better? If so, which helped the most? In what manner? ____________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

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

25. Please write in any other pertinent information that has not been covered previously. ____________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

Date____________________ Patient's Signature

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(TMJ/TMD) Questionnaire (V2014)