Madison Prosthodontics
Aesthetic & Reconstructive Dentistry
Smiles Designed for Life

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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	R ( ) L ( )
b. Pain in ear	R ( ) L ( )
c. Pain around eyes	R ( ) L ( )
d. Pain in lower jaw	R ( ) L ( )
e. Pain in upper jaw	R ( ) L ( )
f. Pain in neck	R ( ) L ( )
g. Pain in shoulder	R ( ) L ( )
h. Pain in forehead	R ( ) L ( )
i. Pain in facial area	R ( ) L ( )
j. Grating sound in joint	R ( ) L ( )
k. Subjective hearing loss	R ( ) L ( )
l. Dizziness (vertigo)	R ( ) L ( )
m. Upset stomach- nausea	R ( ) L ( )
n. Ringing sound in ears (tinnitus)	R ( ) L ( )
o. Headache	R ( ) L ( )
p. Fullness, pressure blockage in ear	R ( ) L ( )
q. Pain in tongue	R ( ) L ( )
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):* _____
_____
_____

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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?_____
ee. 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

_____
_____
_____

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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

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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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