TMJ/Facial Pain Questionnaire

Temporomandibular Joint Problems

Patient Name:____ Today's Date:_____/_____/_____

Who referred you to this office? ______________________________

History

How long has this problem occurred? ☐ 1 mo. ☐ 3 mo. ☐ 6 mo. ☐ 6-12 mos. ☐ Over 1 year ☐ Over 5 years

Can you remember any accident in which you hit or injured your jaw? ☐ Yes ☐ No

At what age? ________ Describe:____

____

Have you ever had orthodontics (braces)? ☐ Yes ☐ No How long ago? ________________________

Do you clench your jaws? ☐ Yes ☐ No At night? ☐ Yes ☐ No During the day? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No At night? ☐ Yes ☐ No During the day? ☐ Yes ☐ No

Are your teeth sensitive? ☐ Yes ☐ No

Has your jaw ever "locked" or slipped out of place? ☐ Yes ☐ No

Are you taking medicine of any kind? ☐ Yes ☐ No

List Medications and Reasons for taking:____

____

____

____

____

Have you been treated for this problem by any other doctor? ☐ Yes ☐ No

If so, Dr. Name: ______________________________ Address:______________________________

Treatment:____

Please Check Symptoms and Descriptions That Apply

	YES	Constant	Aching	Stabbing	Burning	Worse in AM	Worse in PM	When opening wide	When Chewing
Ear pain									
Face pain									
Neck pain									
Jaw pain									
Eye pain or burning									
Hearing problem									
Headaches									
Sore and sensitive teeth									
Pain in front of the ear									
Dizziness									

Does your jaw: ☐ Click or pop? ☐ Catch or "hang up" ☐ Make a grinding sound? ☐ Lock open? ☐ Lock closed?

If none of these symptoms are occurring now, have any of these occurred in the past? ☐ Yes ☐ No

If yes, please explain:____

____

Please indicate the area of your pain on the illustration:

Describe the problem in your own words:______________

____

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____

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____

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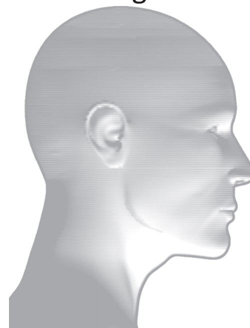
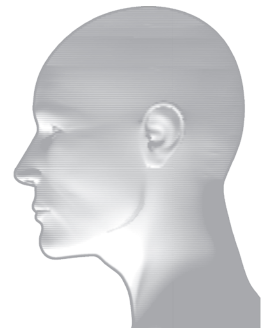
Your Right Side



Your Left Side



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