TMJ HEALTH QUESTIONNAIRE

PATIENT NAME _____ Date _____

CHIEF COMPLAINT _____

DO YOU FEEL YOU NEED TREATMENT FOR THIS PROBLEM ☐ YES ☐ NO

DATE OF ONSET _____

PAIN SYMPTOMS

Do you get tension headaches?	Y	N
Do you get migraine headaches?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N
Do you have trouble sleeping soundly?	Y	N
Have your teeth been sore upon awakening?	Y	N
Does your jaw ache when you chew?	Y	N
Do you have ear pain?	Y	N
Does your jaw ache when you open wide?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N

What medication, if any, are you taking?

_____

_____

Do you get headaches in right or left temple areas?	Y	N
Do you get headaches in the back of your head?	Y	N
Do you grind your teeth when asleep?	Y	N
Are your jaws tired when you awaken?	Y	N

When are your symptoms worse?

_____

Does anything make you feel better?

_____

_____

How often do you take medication for relief of pain?

a) Never b) Weekly to Monthly
c) Weekly d) Daily

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw?	Y	N
Any whiplash neck injuries?	Y	N

Have you ever been involved in any serious accidents, such as a car accident? Y N

Details _____

_____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal?	Y	N
Are there any foods you avoid eating?	Y	N
Do you ever get dizzy?	Y	N
Do you ever feel faint?	Y	N
Do you ever feel nauseated (sick)?	Y	N
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N

Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint?	Y	N
Has your jaw ever locked when you were unable to open or close?	Y	N
Do you have difficulty opening wide or yawning?	Y	N
Have you ever had pain in either jaw joint?	Y	N

EAR AND EYE SYMPTOMS

Do you have itchiness or stuffiness in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N
Do you get pain in, around or behind either eye?	Y	N
Are there times when your eyesight blurs?	Y	N
Do you wear glasses or contacts?	Y	N

Do you have any pain in your ears?	Y	N
Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N
Do you hear grating noises in ears? (like sand particles rubbing)	Y	N

BREATHING

Do you have allergies?	Y	N
Do you have sinus problems?	Y	N
Do you snore at night?	Y	N

Do you still feel sleepy upon awakening?	Y	N
Do you wake up with headaches?	Y	N
Are you sleepy during the daytime?	Y	N

SIGNATURE _____

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