Temporomandibular Joint Dysfunction (TMJ)

Questionnaire

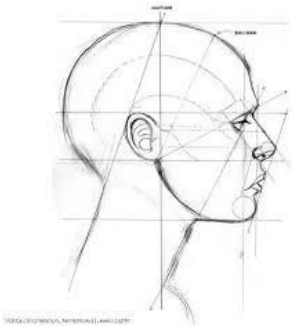
OraMax
Oral-Maxillofacial & Implant Specialists

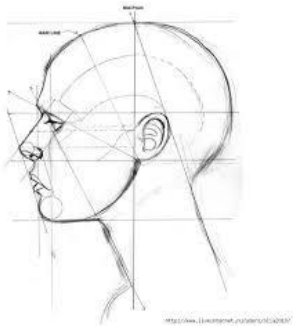
Name:_____
Date: _____
Age: _____
Referred By: _____

Describe your problem:

_____

On the figures to the right, please outline where your pain is located.





Which side hurts? ☐ Right ☐ Left ☐ Both
For how long?
Is pain constant or intermittent?

When is the pain worse? ☐ Morning ☐ Afternoon ☐ Evening

Does it hurt to move your jaw? ☐ Yes ☐ No

Does it hurt to chew? ☐ Yes ☐ No

Does your jaw make noise? ☐ Clicking ☐ Grinding ☐ Other
When: For how long:

Has your jaw ever locked open? ☐ Yes ☐ No

Has your jaw locked closed? ☐ Yes ☐ No
When: How often:

Have you ever suffered from: ☐ Headaches ☐ Neckaches ☐ Shoulder Pain
☐ Ear Pain ☐ Dizziness ☐ Change in Hearing

Do you grind or clench your teeth? ☐ At night ☐ During the day

Do you have sore or sensetive teeth? ☐ Yes ☐ No ☐ Sometimes

Do you have trouble getting to sleep? ☐ Yes ☐ No ☐ Sometimes

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Do you sleep well? ☐ Yes ☐ No ☐ Sometimes

Are you under a lot of stress? ☐ Yes ☐ No ☐ Sometimes

Are you nervous or anxious about anything? ☐ Yes ☐ No ☐ Sometimes

Have you had a nervous stomach or ulcers? ☐ Yes ☐ No ☐ Sometimes

Do you have or have you ever had arthritis? ☐ Yes ☐ No ☐ Sometimes

Does your pain keep you from doing anything? ☐ Yes ☐ No

If yes, what?

Can you remember any injury to your jaw? ☐ Yes ☐ No

If yes, describe?

Do you take medications for the pain? ☐ Yes ☐ No

If yes, what?

Do you take medications for relaxation? ☐ Yes ☐ No

If yes, what?

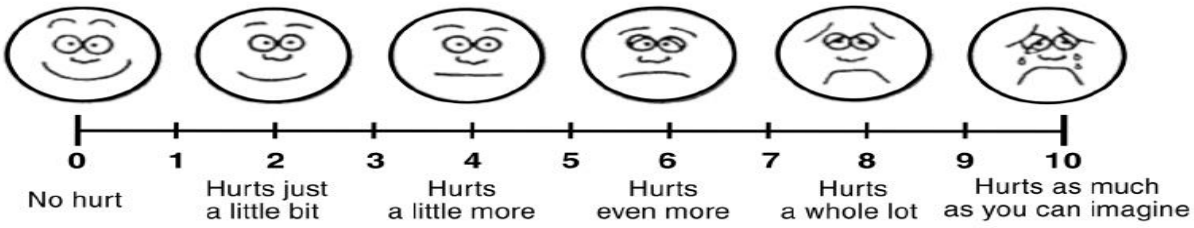
Have you had any treatments for your problem? ☐ Yes ☐ No

If yes, what?

Please check any treatments you have had: ☐ Bite Splint ☐ Medication ☐ Physical therapy

☐ Counseling ☐ Occlusal adjustment ☐ Orthodontics ☐ Surgery ☐ Other

Rate your pain now:



At its worst, how bad is your pain: