TMJ History Questionnaire

Name _____ Age ____ Sex ____ Date _____

1. Do you have noises in either jaw joint? Right jaw joint? YES NO
   [ ] Clicking [ ] Popping [ ] Grating [ ] Crackling [ ] Other _____
   Left jaw joint? YES NO
   [ ] Clicking [ ] Popping [ ] Grating [ ] Crackling [ ] Other _____

2. When did you first notice the noise? _____

3. Has the noise changed recently in any way? YES NO
   If yes, please describe how and when: _____
   _____

4. Do you have pain in or around either jaw joint? Right jaw joint? YES NO
   Left jaw joint? YES NO
   If yes, please describe in detail: _____
   _____
   _____

5. When did you first notice the pain? _____

6. Has the pain changed recently in any way? YES NO
   Please describe how and when: _____
   _____

7. Rate the pain at the following times on a scale of 0 (none) to 10 (terrible):
   Morning ____ Afternoon ____ Evening ____ Sleeping ____
   At meals ____ Talking ____ Wide Opening ____ Other ____

8. Does the problem involve your ears? Check all that apply:
   [ ] Ear Pain [ ] Ear popping [ ] Ringing in the ear [ ] Hearing problems [ ] Other _____

9. Does your jaw problem interfere with your normal activities? YES NO

If yes, please describe how and why: _____

_____

10. What medications are you taking or have taken for this problem? _____

_____

11. Did anything ever happen (facial trauma, unusual opening or biting, dental work/surgery, intubation, motor vehicle accident, neck or back injury, etc.) prior to this problem? _____

_____

_____

_____

12. Do you have problems with jaw movement / function? Check all that apply:

[ ] Unable to open wide [ ] Unable to close completely [ ] Problems moving to sides R / L

[ ] Locking [ ] Chewing [ ] Bite feels "off" [ ] Grinding [ ] Clenching [ ] Sore Teeth

13. How often do you have headaches and when do you get them? _____

_____

14. Do you have any other joint problems? YES NO

If yes, please describe: _____

_____

15. Do you have back, neck, or postural problems? YES NO

If yes, please describe: _____

_____

_____

16. Have you ever had orthodontic treatment? YES NO

If yes, please describe: _____

_____

17. Have you ever had a bite equilibration or occlusal / bite adjustment? YES NO

If yes, please describe: _____

_____

18. Please tell us anything else that comes to mind concerning any issues that may be related. _____

_____

_____