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

BREATHING

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

Is your nose stuffed when you don't have have a cold? Y N
Have you been diagnosed with Sleep Apnea? Y N
Have you had a sleep study done at a Sleep Clinic (hospital)? Y N

SIGNATURE ______________________________

Please tell us why you have presented for evaluation and possible treatment:

Crowding________ Overbite________ Don't Like My Smile________ Appearance________

Better Function________ Airway Assessment________ Teasing at School________

My dentist found the problem________ I/We don't see a problem________

Any Habit(s) ❑ Yes ❑ No If yes, please check which one(s):

Thumb sucking?________ Tongue habit?________ Mouth Breathing?________

Any other reason?________

MEDICAL HISTORY

General Health	❑ Good	❑ Fair	Poor ________
Under Treatment	❑ Yes	❑ No	Specify ________
Drugs or Medication	❑ Yes	❑ No	Specify ________

HAS PATIENT EVER HAD ANY OF THE FOLLOWING:

Arthritis	Y	N	Congenital Heart Defects	Y	N
Heart Attack or Stroke	Y	N	Mitral Valve Prolapse	Y	N
Allergies	Y	N	Diabetes	Y	N
Heart Murmur	Y	N	Nervous Disorder	Y	N
Artificial Joints	Y	N	Dizziness	Y	N
Heart Surgery/Pacemaker	Y	N	Numbness of Arms/Hands	Y	N
Anemia	Y	N	Emotional Problems	Y	N
Hearing Disorders	Y	N	Pneumonia	Y	N
Arteriosclerosis	Y	N	Epilepsy	Y	N
Hepatitis	Y	N	Psychiatric Treatment	Y	N
Asthma	Y	N	Emphysema	Y	N
High/Low Blood Sugar	Y	N	Ulcers	Y	N
AIDS/HIV	Y	N	Fainting	Y	N
History of Substance Abuse	Y	N	Rheumatic Fever	Y	N
Birth Defects	Y	N	Fever or Sun Blisters	Y	N
Hypertension (High BP)	Y	N	Swollen, Stiff, Painful Joints	Y	N
Blood Disorders	Y	N	Glaucoma	Y	N
Hypotension (Low BP)	Y	N	Scarlet Fever	Y	N
Bruises Easily	Y	N	Hay Fever	Y	N
Intestinal Disorders	Y	N	Shortness of Breath	Y	N
Cancer	Y	N	Herpes	Y	N
Kidney Problems	Y	N	Sinus Problems	Y	N
Cosmetic Surgery	Y	N	Head or Face Injury	Y	N
Liver Problems	Y	N	Thyroid Problems	Y	N

Have the tonsils or adenoids been removed?	❑ Yes	❑ No	What Age? ________
Does the patient have a tendency for colds?	❑ Yes	❑ No	
Sore throats?	❑ Yes	❑ No	
Ear infections?	❑ Yes	❑ No	
Has the patient ever had tubes in their ears?	❑ Yes	❑ No	What Age? ________

DENTAL HISTORY

Has the patient ever sucked their thumb or finger?	❑ Yes	❑ No	Until what age? ________
Does the patient have any speech problems?	❑ Yes	❑ No	
Does the patient breathe through the mouth?	❑ Day	❑ Night	❑ No
Has either parent had previous ortho treatment?	❑ Yes	❑ No	
Does the patient play any musical (mouth) instruments?	❑ Yes	❑ No	
Have you consulted an orthodontist or another dentist regarding the orthodontic or TMJ problem?	❑ Yes	❑ No	

Patient/Guardian Signature ________________ **Date** ________________