**TMJ HEALTH QUESTIONNAIRE**

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| --- | --- | --- |
| Patient Last Name:Click here to enter text. | Patient First Name: Click here to enter text. | Middle Initial: Click here to enter text. |
| Date: Click here to enter a date. |

|  |  |
| --- | --- |
| Chief Concern:  | Click here to enter text. |
| Date of Onset:  | Click here to enter a date. |

**PAIN SYMPTOMS**

|  |  |  |
| --- | --- | --- |
| Do you get “tension headaches”? | [ ]  Yes | [ ]  No |
| Do you ever get “migraine headaches”? | [ ]  Yes | [ ]  No |
| Do you frequently have neckaches or still neck muscles? | [ ]  Yes | [ ]  No |
| Do you have trouble sleeping soundly? | [ ]  Yes | [ ]  No |
| Have your teeth been sore upon awakening? | [ ]  Yes | [ ]  No |
| Does your jaw ache when you chew? | [ ]  Yes | [ ]  No |
| Do you have ear pain? | [ ]  Yes | [ ]  No |
| Does your jaw ache when you open wide? | [ ]  Yes | [ ]  No |
| Have you ever had chronic shoulder or back pain? | [ ]  Yes | [ ]  No |
| What medications, if any, are you taking? Click here to enter text. |
| How often do you take medicine for relief of pain? | [ ]  Daily | [ ]  Weekly | [ ]  Monthly | [ ]  Never |
| Do you get headaches in the right or left temple area? | [ ]  Yes | [ ]  No |
| Do you get headaches in the back of your head? | [ ]  Yes | [ ]  No |
| Do you grind your teeth when asleep? | [ ]  Yes | [ ]  No |
| Are your jaws tired when you awaken from sleep? | [ ]  Yes | [ ]  No |
| When are your symptoms the worst? Click here to enter text. |
| Does anything make you feel better? Click here to enter text. |
| Have your wisdom teeth been extracted? | [ ]  Yes | [ ]  No |
| If yes, please provide details: Click here to enter text. |

**TRAUMA OR ACCIDENTS**

|  |  |  |
| --- | --- | --- |
| Have you ever had a severe blow to head or jaw? | [ ]  Yes | [ ]  No |
| Any whiplash neck injuries? | [ ]  Yes | [ ]  No |
| Have you ever been involved in any serious accidents, such as a car accident? | [ ]  Yes | [ ]  No |
| If yes, please provide details: Click here to enter text. |

**JAW JOINT SYMPTOMS**

|  |  |  |
| --- | --- | --- |
| Does your jaw feel tired after a big meal? | [ ]  Yes | [ ]  No |
| Are there any foods you avoid eating? | [ ]  Yes | [ ]  No |
| Do you ever get dizzy? | [ ]  Yes | [ ]  No |
| Do you ever feel faint? | [ ]  Yes | [ ]  No |
| Do you feel nauseated (sick)? | [ ]  Yes | [ ]  No |
| Is there a family history of jaw joint (TMJ) problems or headaches? | [ ]  Yes | [ ]  No |
| Do you feel or hear a “clicking”, “popping” or “cracking” noise from either jaw joint? | [ ]  Yes | [ ]  No |
| Has your jaw ever locked where you were unable to open or close? | [ ]  Yes | [ ]  No |
| Do you have difficulty opening wide or yawning? | [ ]  Yes | [ ]  No |
| Have you ever had pain in either jaw joint? | [ ]  Yes | [ ]  No |

**EAR AND EYE SYMPTOMS**

|  |  |  |
| --- | --- | --- |
| Do you have itchiness or stuffiness in either ear? | [ ]  Yes | [ ]  No |
| Do you suffer from any loss of hearing? | [ ]  Yes | [ ]  No |
| Do you get pain in, around or behind either eye? | [ ]  Yes | [ ]  No |
| Are there times when your eyesight blurs? | [ ]  Yes | [ ]  No |
| Do you hear ringing, buzzing or hissing sounds in either ear? | [ ]  Yes | [ ]  No |
| Do you hear grating noises in ears? (like sand particles rubbing) | [ ]  Yes | [ ]  No |
| Do you hear glasses or contacts? | [ ]  Yes | [ ]  No |

**BREATHING**

|  |  |  |
| --- | --- | --- |
| Do you have allergies? | [ ]  Yes | [ ]  No |
| Do you have sinus problems? | [ ]  Yes | [ ]  No |
| Do you snore at night? | [ ]  Yes | [ ]  No |
| Is your nose stuffed when you have don’t a cold? | [ ]  Yes | [ ]  No |