**TMJ HEALTH QUESTIONNAIRE**

|  |  |  |
| --- | --- | --- |
| 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 |