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TMJ HEALTH QUESTIONNAIRE

Patient Last Name:	Patient First Name:	Middle Initial:
Date:		

Chief Concern:	
Date of Onset:	

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?		
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?		
Does anything make you feel better?		
Have your wisdom teeth been extracted?	☐ Yes	☐ No
If yes, please provide details:		

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:		

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