TMJ QUESTIONNAIRE

DATE: .....

NAME: .....

I. MEDICAL / DENTAL HISTORY

A. General Health:

1. Physical ..... ☐ **Good** ☐ **Fair** ☐ **Poor**
2. Emotional ..... ☐ **Good** ☐ **Fair** ☐ **Poor**

	Yes	**No**
B. Do you have a personal physician?	☐	☐
C. Are you currently under the care of a physician?	☐	☐
D. Have you ever been seriously ill?	☐	☐
E. Have you been hospitalized in the past 5 years?	☐	☐
F. Have you ever had a major operation?	☐	☐
G. Women: Are you pregnant?	☐	☐
H. Has there been any change in your general health in the last year	☐	☐
I. Has there been a major weight loss, without dieting, in recent months?	☐	☐
J. Worried about receiving medical/dental treatment?	☐	☐

K. Have you now, or in the past, experienced any of the following medical conditions?:

- ☐ Allergies
- ☐ Addiction
- ☐ Anemia (low blood cell count)
- ☐ Arthritis
- ☐ Asthma
- ☐ Arteriosclerosis
- ☐ Bleeding Problems
- ☐ Blood Diseases
- ☐ Blood Pressure–high
- ☐ Blood Pressure–low
- ☐ Blood Transfusions
- ☐ Bone Disorder
- ☐ Breathing or Lung Disorder
- ☐ Cancer
- ☐ Chronic pain condition
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/substance abuse
- ☐ Epilepsy
- ☐ Endocrine problems
- ☐ Female problems
- ☐ Gastrointestinal (GI) problems (ulcers)
- ☐ Genitourinary problems
- ☐ Heart Disease
- ☐ Hearing disorder, ringing ears
- ☐ Hepatitis
- ☐ HIV / AIDS / ARC (circle)
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Migraine headaches
- ☐ Musculo–skeletal disorder
- ☐ Neurological disorder
- ☐ Psychiatric disorder
- ☐ Rheumatic fever
- ☐ Sleep disturbance (snoring, night gasping)
- ☐ Stroke
- ☐ Venereal Disease
- ☐ OTHER _____

L. Medications currently taken by the patient?

- ☐ None
- ☐ Antibiotics
- ☐ Birth control pills/hormones
- ☐ Diet Pills (Diuretics)
- ☐ Heart Pills (Digitalis, etc.)
- ☐ Insulin
- ☐ Muscle Relaxants (Valium, etc.)
- ☐ Pain Pills (Demerol, Codeine, etc.)
- ☐ Sleeping pills (Barbiturates)
- ☐ Tranquilizers (Valium, etc.)
- ☐ OTHER _____

M. Allergies to medicine and/or food?:

- ☐ None
- ☐ Antibiotics
- ☐ Dairy Products
- ☐ Dental anesthetics
- ☐ Dyes in foods
- ☐ Metals
- ☐ Pain pills
- ☐ Wheat, cereals
- ☐ OTHER _____

II. CRANIOFACIAL SYMPTOMS OF THE HEAD, NECK AND FACE

Fill in the appropriate response square indicating whether or not you currently have, or previously had, the following conditions or symptoms, and identify which side, right side **R** of **L** where appropriate. If both sides are involved, mark right and left sides.

	Current Condition	
1. Bleeding gums and/or gum disease?	☐ R	☐ L
2. Crowns on teeth and/or caps?	☐ R	☐ L
3. Do you chew gum regularly?	☐ R	☐ L
4. Do you feel that your bite closed?	☐ R	☐ L
5. Do you feel that there is not enough room for your tongue?	☐ R	☐ L
6. Missing back teeth with no replacement?	☐ R	☐ L
7. Oral Surgery?	☐ R	☐ L
8. Orthodontic treatment?	☐ R	☐ L
9. Periodontal disease (Pyrrohea)?	☐ R	☐ L
10. Sore or painful teeth?	☐ R	☐ L
11. Teeth sensitive to cold and/or hot?	☐ R	☐ L
12. Teeth badly worn?	☐ R	☐ L
13. Teeth have been ground by dentist?	☐ R	☐ L
14. Teeth feel very loose?	☐ R	☐ L

15. Teeth extracted within the past three years? ☐R ☐L
16. TMJ (jaw joint) treatment? ☐R ☐L
17. Treated for a bad bite? ☐R ☐L
18. Wisdom teeth removed? ☐R ☐L
19. Do you have frequent canker sores or cold sores? ☐R ☐L

A. CRANIOFACIAL PAIN

	Yes	No
1. Do you have generalized facial pain?	☐	☐
2. On which side is there constant or recurring pain?	☐	☐
3. Does the pain or discomfort disturb your sleep?	☐	☐
4. Would you describe the pain as a dull, aching sensation?	☐	☐
5. Would you describe the pain as stabbing, sharp, severe sensation?	☐	☐
6. Do you suffer from chronic headache?	☐	☐
7. Do you ever have migraine headaches?	☐	☐
8. Do you have tension headaches?	☐	☐
9. Headaches in right or left temple?	☐	☐
10. Headaches in the back of the head?	☐	☐
11. Are there times when you notice that the pain or problems are less or gone completely?	☐	☐
12. Do you have pain in teeth on awakening?	☐	☐
13. Do you r teeth hurt from clenching or chewing?	☐	☐
14. Does your jaw ache when you chew?	☐	☐
15. Does your jaw hurt when you open wide or take a big bite?	☐	☐
16. Does it now hurt to open wide?	☐	☐
17. Do you have ear pain?	☐	☐
18. Do you have pain in front of the ears?	☐	☐
19. Is the degree of pain same in morning as evenings?	☐	☐
20. Do you have chronic stiff neck?	☐	☐
21. Do you have neckaches (neck pain)?	☐	☐
22. Have you ever had chronic shoulder or back pain?	☐	☐

23. **When are your symptoms worse?:**
- ☐ Upon rising in the morning
- ☐ At work
- ☐ At the end of the workday
- ☐ At home
- ☐ At school

	Yes	No
24. Have you ever been treated for pain?	☐	☐
25. Have you ever had injections or nerve blocks for pain?	☐	☐
26. Did any of the injections bring relief from pain?	☐	☐
27. Have you ever been operated on to relieve pain?	☐	☐
28. Did the operation bring relief from pain?	☐	☐

29. **How often do you take medicine for the relief of pain?**
- ☐ Never
- ☐ Seldom (a few times a year)
- ☐ Occasionally (once a month)
- ☐ Often (weekly)
- ☐ Frequently (daily)

B. BREATHING PROBLEMS

	Yes	No
1. Allergies?	☐	☐
2. Does your nose feel stuffy when you don't have a cold?	☐	☐
3. Does your nose run when you don't have a cold?	☐	☐
4. Sinus problems?	☐	☐
5. Do you snore?	☐	☐
6. Mouth breather?	☐	☐
7. Do you have sleep apnea?	☐	☐

C. EYE PROBLEMS

	Yes	No
1. Pain in, around, or behind eyes?	☐	☐
2. Eyesight blurs?	☐	☐
3. Eyelid tics (twitches)?	☐	☐
4. Eyes blink excessively?	☐	☐
5. Do your eyes water most of the time (tearing)?	☐	☐

D. EAR PROBLEMS

	Yes	No
1. Earaches or ear pain?	☐	☐
2. Hearing loss?	☐	☐
3. Grating noise in ears (like sand particles)?	☐	☐
4. Itchiness in ears?	☐	☐
5. Stuffiness in ears?	☐	☐
6. Ringing, hissing, or buzzing sounds in ears?	☐	☐
7. Whooshing or throbbing sound in ears?	☐	☐

E. EQUILIBRIUM PROBLEMS

	Yes	No
1. Do you feel lightheaded or dizzy?	☐	☐
2. Often feel like vomiting or nauseated?	☐	☐

F. POSTURE PROBLEMS

	Yes	No
1. Do you have backaches?	☐	☐
2. Do you have an abnormal curvature of the spine?	☐	☐
3. Are your legs of unequal lengths?	☐	☐
4. Do you have problems sitting still for Prolonged time?	☐	☐
5. Do you cradle the phone between your Head and shoulders?	☐	☐
6. Does your work involve typing/word processing?	☐	☐

7. **Do you wear high heels?**
- ☐ Seldom
- ☐ Occasionally
- ☐ Frequently

G. LIFESTYLE PROBLEMS

	Yes	No
1. Are you under a lot of stress?	☐	☐
2. Do you bite your nails, tongue, or lips?	☐	☐
3. Take any mood affecting drugs or stimulants?	☐	☐
4. Do you exercise regularly?	☐	☐
5. Do you usually eat breakfast?	☐	☐
6. Do you work more than 40 hours a week?	☐	☐
7. Do you overeat?	☐	☐

SCHECHTMAN Orthodontics

TMJ QUESTIONNAIRE

H. JAW (TMJ) SYMPTOMS

	Yes	No
1. Have you ever been treated for jaw joint problems, or facial muscle spasms?	☐	☐
2. Do you have difficulty in chewing your food?	☐	☐
3. Do you grind your teeth during the night?	☐	☐
4. Has anyone told you that you grind your teeth?	☐	☐
5. Are you aware of clenching your teeth during the day?	☐	☐
6. Are you aware of clenching your teeth during the night?	☐	☐
7. Are there times when you can't open your mouth widely?	☐	☐
8. Do you have difficulty in opening your Mouth widely?	☐	☐
9. Does it hurt to open your mouth widely?	☐	☐
10. Does your mouth go to one side when Fully opened?	☐	☐
11. Has your jaw ever locked or were you unable to open or close your mouth	☐	☐
12. Have you had pain in your jaw joint? 13.	☐	☐
Do you hear sounds in your jaw joint? 14.	☐	☐
Do you hear grating sounds in your jaw joint?	☐	☐
15. Do you hear or feel a clicking or popping in your jaw joint?	☐	☐
16. Does your jaw make clicking or popping sounds when you chew?	☐	☐
17. Does your jaw feel tired after a big meal?	☐	☐
18. Have you experienced numbness of shoulders, arms, hands, or fingers?	☐	☐
19. Do you have pain in your neck and/or shoulders?	☐	☐

I. TRAUMA RELATED PROBLEMS

	Yes	No
1. Accident or trauma to face?	☐	☐
2. Accident or trauma to jaw?	☐	☐
3. Accident or trauma to head?	☐	☐
4. Have you ever received a severe blow to the side of the head or jaw?	☐	☐
5. Accident or trauma to neck?	☐	☐
6. Whiplash or neck injury?	☐	☐
7. Have you worn a cervical traction neck collar?	☐	☐
8. Has there been a strain or stretching of the Jaw while yawning, chewing, or opening the mouth wide?	☐	☐
9. Have you experienced a fall within the last two years?	☐	☐

J. Are there any other significant medical or dental problems? ☐ Yes ☐ No

III. PRACTITIONERS

Please indicate which practitioners you have seen since your pain began for treatment and relief of pain.

	Have Seen	Now Seeing
1. Acupuncturists	☐	☐
2. Allergist	☐	☐
3. Anesthesiologist	☐	☐
4. Cardiologist (heart)	☐	☐
5. Chiropractor	☐	☐
6. Clergyman	☐	☐
7. Dentist	☐	☐
8. Dermatologist (skin)	☐	☐
9. Dietician	☐	☐
10. E.N.T	☐	☐
11. Endocrinologist	☐	☐
12. Faith Healer	☐	☐
13. Family Physician	☐	☐
14. Gynecologist/Obstetrician	☐	☐
15. Hypnotist	☐	☐
16. Internist	☐	☐
17. Naturopath	☐	☐
18. Neurologist	☐	☐
19. Neurosurgeon	☐	☐
20. Nutritionist	☐	☐
21. Ophthalmologist (eyes)	☐	☐
22. Optometrist	☐	☐
23. Orthopedist (bones, joints)	☐	☐
24. Orthodontist	☐	☐
25. Osteopathic physician	☐	☐
26. Pediatrician (children)	☐	☐
27. Physical therapist	☐	☐
28. Physiatrist	☐	☐
29. Plastic Surgeon	☐	☐
30. Proctologist	☐	☐
31. Psychiatrist	☐	☐
32. Psychologist	☐	☐
33. Radiologist	☐	☐
34. Rheumatologist	☐	☐
35. Surgeon	☐	☐
36. Other 1 _____	☐	☐
37. Other 2 _____	☐	☐

IV. PAIN SUMMARY

Please identify your areas of pain indicating right **R** and/or left **L** that you presently or frequently experience.

	Presently/and or Frequently	
1. Top of head	☐ R	☐ L
2. Back of head	☐ R	☐ L
3. Frontal headache	☐ R	☐ L
4. Eye and eyebrow	☐ R	☐ L
5. Temporal headache	☐ R	☐ L
6. Jaw and cheek	☐ R	☐ L
7. Ear and jaw joint area	☐ R	☐ L
8. Toothache	☐ R	☐ L
9. Front of neck and throat	☐ R	☐ L
10. Side of neck	☐ R	☐ L
11. Back of neck	☐ R	☐ L
12. Upper thoracic of back	☐ R	☐ L
13. Mid-thoracic of back	☐ R	☐ L
14. Lower back	☐ R	☐ L

15. Back of the shoulder ☐R ☐L
16. Front of shoulder ☐R ☐L
17. Back of arm ☐R ☐L
18. Front of arm ☐R ☐L
19. Upper chest area ☐R ☐L

V. BITE AND TOOTH CONCERNS:

	Yes	No
1. Bad bite?	☐	☐
2. Buck teeth/overjet?	☐	☐
3. Crowding of upper teeth?	☐	☐
4. Crossbite?	☐	☐
5. Grinding (Bruxism)?	☐	☐
6. Gummy smile?	☐	☐
7. Mouth too small?	☐	☐
8. Spaces?	☐	☐

VI. HEALTH PROFESSIONAL(S): (Current or have seen previously)

Doctor Name: _____

Reason(s) for treatment: _____

Doctor Name: _____

Reason(s) for treatment: _____

Doctor Name: _____

Reason(s) for treatment: _____

COMMENTS:

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that is not reported above, I will inform the doctor at my next visit. **I am aware of the $95 initial consultation fee at time of service.**

Patient's/Responsible Party's Signature Date

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