Temporal Mandibular Joint (TMJ) Questionnaire

This questionnaire was designed to provide important facts regarding the history of your pain or condition. To assist in reaching a diagnosis and determining the source of your problem, please take your time and answer each question as completely and honestly as possible.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

☐ Back Pain ☐ Dizziness ☐ Ear Congestion ☐ Ear Pain
☐ Eye Pain ☐ Facial Pain ☐ Fatigue ☐ Headaches
☐ Jaw Clicking ☐ Jaw Joint Noise ☐ Jaw Locking Jaw Pain
☐ Limited Mouth Opening ☐ Muscle Soreness ☐ Muscle Twitching
☐ Neck Pain ☐ Pain when chewing ☐ Ringing in the Ears
☐ Shoulder Pain ☐ Sinus Congestion ☐ Throat Pain ☐ Tinnitis
☐ Visual Disturbances
☐ Other _____

TMJ MEDICAL HISTORY:

Injury to… : ☐ FACE ☐ NECK ☐ TEETH ☐ HEAD ☐ MOUTH
☐ Needing extra pillow to help breathing at night
☐ Chronic Fatigue ☐ Prior Orthodontic Treatment
☐ Jaw Joint Surgery ☐ Rheumatoid Arthritis
☐ Muscle Spasms ☐ Swollen, stiff, or painful joints
☐ Meniere's Disease ☐ Teeth Clenching
☐ Muscle Cramps ☐ Teeth Grinding
☐ Osteoarthritis ☐ Wisdom Teeth Extraction

HISTORY OF SYMPTOMS:

1. When did your condition first occur? _____
2. What do you believe is the cause of your pain of condition?
   ☐ Motor Vehicle ☐ Motorcycle Accident ☐ Work related incident
   ☐ Playground incident ☐ Athletic endeavor ☐ Fight
   ☐ Fall ☐ Accident ☐ Illness ☐ Injury ☐ Unknown
   If accident, when (date)? _____
   Other _____
   What other information is important to your pain or condition?-
   _____
   _____
   _____

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LIST TREATMENTS YOU HAVE HAD FOR THIS PROBLEM AND ALL HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING:

Practitioner: **Specify:** **Treatment and Approx Date:**

1._____

2._____

3._____

4._____

IF YOU HAVE HEAD PAIN INDICATE LOCATION AND TYPE

L= LEFT ***R= RIGHT*** ***B= BOTH SIDES***

	SEVERITY			**FREQUENCY**			**DURATION**				
	MILD	MOD	SEVERE	OCC	FREQ	CONSTANT	SEC	MIN	HRS	DAYS	WK
L◉R○B○ Front your head (Frontal)	○	○	○	○	○	○	○	○	○	○	○
L◉R○B○ Entire head (Generalized)	○	○	○	○	○	○	○	○	○	○	○
L◉R○B○ Top of your head (Parietal)	○	○	○	○	○	○	○	○	○	○	○
L○R○B○ Back of your head (Occipital)	○	○	○	○	○	○	○	○	○	○	○
L○R○B○ In your temples (Temporal)	○	○	○	○	○	○	○	○	○	○	○

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

***SIGNATURE OF PATIENT, PARENT, or GUARDIAN:** **DATE:**

_____ _____

Review by: Doctor _____Date_____
B.P. _____

Medical Updates: _____ Date _____
Dr. _____

Medical Updates: _____ Date _____
Dr. _____