

TMJ QUESTIONNAIRE

I. MEDICAL/ DENTAL HISTORY

A. General Health:

- | | Good | Fair | Poor |
|-------------------|--------------------------|--------------------------|--------------------------|
| 1. Physical..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Emotional..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- B. Do you have a personal physician?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- C. Are you currently under the care of a physician?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- D. Have you ever been seriously ill?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- E. Have you been hospitalized in the past 5 years?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- F. Have you ever had a major operation?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- G. Women: Are you pregnant?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- H. Has there been any change in your general health in the last year?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- I. Has there been a major weight loss, without dieting, in recent months?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- J. Worried about receiving medical/dental treatment?.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

- K. Have you now, or in the past, experienced any of the following medical conditions:.....**
- | | Yes | No |
|--|--------------------------|--------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Anemia (low blood cell count) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Blood Pressure – high | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Blood Pressure – low | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Breathing on Lung Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

- 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.)
- Actonel or Fosamax
- OTHER _____

M. Allergies to medical 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: of both sides are involved, mark right and left sides.

- | | Current Condition | |
|---|----------------------------|----------------------------|
| | <input type="checkbox"/> R | <input type="checkbox"/> L |
| 1. Bleeding gums and/or gum disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Crowns on teeth and/or caps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Headaches in right or left temple? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel that your bite closed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you feel that there is not enough room for your tongue? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Missing back teeth with no replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Oral Surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Orthodontic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Periodontal disease (pyrrohea)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Sore or painful teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Teeth sensitive to cold and/or hot? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Teeth badly worn? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Teeth have been ground by dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Teeth feel very loose? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Teeth extracted within the past three years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. TMJ (jaw joint) treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Treated for a bad bite? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Wisdom teeth removed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have frequent canker sores or cold sores? | <input type="checkbox"/> | <input type="checkbox"/> |

A. CRANIOFACIAL PAIN

- | | Yes | No |
|--|--------------------------|--------------------------|
| 20. Do you have generalized facial pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Is there constant or recurring pain on just one side? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does the pain or discomfort disturb your sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Would you describe the pain as a dull, aching sensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Would you describe the pain as stabbing, sharp, severe sensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you suffer from chronic headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you ever have migraine headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have tension headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you chew gum regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Headaches in the back of the head? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Are there times when you notice that the pain or problems are less or gone completely? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have pain in teeth on awakening? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do your teeth hurt from clenching or chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Does your jaw ache when you chew? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Does your jaw hurt when you open wide or take a big bite? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Does it now hurt to open wide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you have ear pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do you have pain on front of the ears? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 38. Is the degree of pain same in morning as evenings? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you have chronic stiff neck? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you have neckaches (neck pain)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Have you ever had chronic shoulder or back pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. When are your symptoms worse: | | |
| <input type="checkbox"/> Upon rising in the morning? | | |
| <input type="checkbox"/> At work? | | |
| <input type="checkbox"/> At the end of the workday? | | |
| <input type="checkbox"/> At home? | | |
| <input type="checkbox"/> At school? | | |

- | | Yes | No |
|--|--------------------------|--------------------------|
| 43. Have you ever been treated for pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Have you ever had injections or nerve blocks for pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Did any of the injections bring relief from pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Have you ever been operated on to relieve pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Did the operation bring relief from pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How often do you take medicine for the relief of pain? | | |
| <input type="checkbox"/> Never | | |
| <input type="checkbox"/> Seldom (a few times a year) | | |
| <input type="checkbox"/> Occasionally (once a month) | | |
| <input type="checkbox"/> Often (weekly) | | |
| <input type="checkbox"/> Frequently (daily) | | |

B. BREATHING PROBLEMS

- | | Yes | No |
|--|--------------------------|--------------------------|
| 49. Allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Does your nose feel stuffy when you don't have a cold? | <input type="checkbox"/> | <input type="checkbox"/> |
| 51. Does your nose run when you don't have a cold? | <input type="checkbox"/> | <input type="checkbox"/> |
| 52. Sinus problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 53. Do you snore? | <input type="checkbox"/> | <input type="checkbox"/> |
| 54. Mouth breather? | <input type="checkbox"/> | <input type="checkbox"/> |
| 55. Do you have sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |

C. EYE PROBLEMS

- | | Yes | No |
|--|--------------------------|--------------------------|
| 56. Pain in, around, or behind eyes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 57. Eyesight blurs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 58. Eyelid tics (twitches)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 59. Eyes blind excessively? | <input type="checkbox"/> | <input type="checkbox"/> |
| 60. Do your eyes water most of the time (tearing)? | <input type="checkbox"/> | <input type="checkbox"/> |

D. EAR PROBLEMS

- | | Yes | No |
|--|--------------------------|--------------------------|
| 61. Earaches or ear pain? | <input type="checkbox"/> | <input type="checkbox"/> |
| 62. Hearing loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 63. Grating noise in ears (like sand particles)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 64. Itchiness in ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| 65. Stiffness in ears? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 66. Ringing, hissing, or buzzing sounds in ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| 67. Whooshing or throbbing sound in ears? | <input type="checkbox"/> | <input type="checkbox"/> |

E. EQUILIBRIUM PROBLEMS

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 68. Do you feel lightheaded or dizzy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 69. Often feel like vomiting or nauseated? | <input type="checkbox"/> | <input type="checkbox"/> |

F. POSTURE PROBLEMS

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 70. Do you have backaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 71. Do you have an abnormal curvature of the spine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 72. Are your legs of unequal lengths? | <input type="checkbox"/> | <input type="checkbox"/> |
| 73. Do you have problems sitting still for prolonged time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 74. Do you cradle the phone between your head and shoulders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 75. Does your work involve typing/word processing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 76. Do you wear high heels | | |
| <input type="checkbox"/> Seldom | | |
| <input type="checkbox"/> Occasionally | | |
| <input type="checkbox"/> Frequently | | |

G. LIFESTYLE PROBLEMS

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 77. Are you under a lot of stress? | <input type="checkbox"/> | <input type="checkbox"/> |
| 78. Do you bite your nails, tongue, or lips? | <input type="checkbox"/> | <input type="checkbox"/> |
| 79. Take any mood affecting drugs or stimulants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 80. Do you exercise regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 81. Do you usually eat breakfast? | <input type="checkbox"/> | <input type="checkbox"/> |
| 82. Do you work more than 40 hours a week? | <input type="checkbox"/> | <input type="checkbox"/> |
| 83. Do you overeat? | <input type="checkbox"/> | <input type="checkbox"/> |

H. JAW (TMJ) SYMPTOMS

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 84. Have you ever been treated for jaw joint problems, or facial muscle spasms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 85. Do you have difficulty in chewing your food? | <input type="checkbox"/> | <input type="checkbox"/> |
| 86. Do you grind your teeth during the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 87. Has anyone told you that you grind your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 88. Are you aware of clenching your teeth during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 89. Are you aware of clenching your teeth during the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 90. Are there times when you can't open your mouth widely? | <input type="checkbox"/> | <input type="checkbox"/> |
| 91. Do you have difficulty in opening your mouth widely? | <input type="checkbox"/> | <input type="checkbox"/> |
| 92. Does it hurt to open your mouth widely? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 93. Does your mouth go to one side when fully opened? | <input type="checkbox"/> | <input type="checkbox"/> |
| 94. Has your jaw ever locked or were you unable to open or close you mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 95. Have you had pain in your jaw joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 96. Do you hear sounds in your jaw joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 97. Do you hear grating sounds in your jaw joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 98. Do you hear or feel a clicking or popping in your jaw joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 99. Does your jaw make clicking or popping sounds when you chew? | <input type="checkbox"/> | <input type="checkbox"/> |
| 100. Does your jaw feel tired after a big meal? | <input type="checkbox"/> | <input type="checkbox"/> |
| 101. Have you experienced numbness of shoulders, arms, hands, or fingers? | <input type="checkbox"/> | <input type="checkbox"/> |
| 102. Do you have pain in your neck and/or shoulders? | <input type="checkbox"/> | <input type="checkbox"/> |

I. TRAUMA RELATED PROBLEMS

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 103. Accident or trauma to face? | <input type="checkbox"/> | <input type="checkbox"/> |
| 104. Accident or trauma to jaw? | <input type="checkbox"/> | <input type="checkbox"/> |
| 105. Accident or trauma to head? | <input type="checkbox"/> | <input type="checkbox"/> |
| 106. Have you ever received a severe blow to the side of the head or jaw? | <input type="checkbox"/> | <input type="checkbox"/> |
| 107. Accident or trauma to neck? | <input type="checkbox"/> | <input type="checkbox"/> |
| 108. Whiplash or neck injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 109. Have you worn a cervical traction neck collar? | <input type="checkbox"/> | <input type="checkbox"/> |
| 110. Has there been a strain or stretching of the jaw while yawning, chewing, or opening the mouth wide? | <input type="checkbox"/> | <input type="checkbox"/> |
| 111. Have you experienced a fall within the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |

J. Are there any other significant medical or dental problems?

- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Allergist | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Anesthesiologist | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Cardiologist (heart) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Chiropractor | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Clergyman | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Dentist | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Dermatologist (skin) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Dietician | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. E.N.T. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Endocrinologist | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Faith Healer | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Family Physician | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Gynecologist/Obstetrician | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Hypnotist | <input type="checkbox"/> | <input type="checkbox"/> |

	Have Seen	Now Seeing
16. Internist	<input type="checkbox"/>	<input type="checkbox"/>
17. Naturopath	<input type="checkbox"/>	<input type="checkbox"/>
18. Neurologist	<input type="checkbox"/>	<input type="checkbox"/>
19. Neurosurgeon	<input type="checkbox"/>	<input type="checkbox"/>
20. Nutritionist	<input type="checkbox"/>	<input type="checkbox"/>
21. Ophthalmologist (eyes)	<input type="checkbox"/>	<input type="checkbox"/>
22. Optometrist	<input type="checkbox"/>	<input type="checkbox"/>
23. Orthopedist (bones, joints)	<input type="checkbox"/>	<input type="checkbox"/>
24. Orthodontist	<input type="checkbox"/>	<input type="checkbox"/>
25. Osteopathic physician	<input type="checkbox"/>	<input type="checkbox"/>
26. Pediatrician (children)	<input type="checkbox"/>	<input type="checkbox"/>
27. Physical therapist	<input type="checkbox"/>	<input type="checkbox"/>
28. Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
29. Plastic Surgeon	<input type="checkbox"/>	<input type="checkbox"/>
30. Proctologist	<input type="checkbox"/>	<input type="checkbox"/>
31. Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>
32. Psychologist	<input type="checkbox"/>	<input type="checkbox"/>
33. Radiologist	<input type="checkbox"/>	<input type="checkbox"/>
34. Rheumatologist	<input type="checkbox"/>	<input type="checkbox"/>
35. Surgeon	<input type="checkbox"/>	<input type="checkbox"/>
36. Other 1	<input type="checkbox"/>	<input type="checkbox"/>
37. Other 2	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS:

IV. PAIN SUMMARY

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

1. Top of head	<input type="checkbox"/> R	<input type="checkbox"/> L
2. Back of head	<input type="checkbox"/> R	<input type="checkbox"/> L
3. Frontal headache	<input type="checkbox"/> R	<input type="checkbox"/> L
4. Eye and eyebrow	<input type="checkbox"/> R	<input type="checkbox"/> L
5. Temporal headache	<input type="checkbox"/> R	<input type="checkbox"/> L
6. Jaw and cheek	<input type="checkbox"/> R	<input type="checkbox"/> L
7. Ear and jaw joint area	<input type="checkbox"/> R	<input type="checkbox"/> L
8. Toothache	<input type="checkbox"/> R	<input type="checkbox"/> L
9. Front of neck and throat	<input type="checkbox"/> R	<input type="checkbox"/> L
10. Side of neck	<input type="checkbox"/> R	<input type="checkbox"/> L
11. Back of neck	<input type="checkbox"/> R	<input type="checkbox"/> L
12. Upper thoracic of back	<input type="checkbox"/> R	<input type="checkbox"/> L
13. Mid-thoracic of back	<input type="checkbox"/> R	<input type="checkbox"/> L
14. Lower back	<input type="checkbox"/> R	<input type="checkbox"/> L
15. Back of shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L
16. Front of shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L
17. Back of arm	<input type="checkbox"/> R	<input type="checkbox"/> L
18. Front of arm	<input type="checkbox"/> R	<input type="checkbox"/> L
19. Upper chest area	<input type="checkbox"/> R	<input type="checkbox"/> L

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.

Patients/Responsible Party Signature

Date