

# Facial Pain and TMJ Patient Questionnaire

In order for us to provide you with optimum care in the diagnosis and treatment of your condition, your cooperation is needed in providing us with all the necessary information. Please complete the following questions as accurately and completely as possible and return them to our office five days before your appointment.

## TMJ Evaluation

What is the nature of your pain or problems? (headache, earache, neckache, etc.)

Describe your pain disorder.

When did you first notice that you had the pain or problem?

Date:

List the names (chronological order) of the health professionals you have seen for treatment.

1.	5.
2.	6.
3.	7.
4.	8.

In your opinion, were any of these treatments effective; if so, for how long?

List the medication you are NOW taking, OR HAVE TAKEN, FOR THIS PROBLEM.

List ALL medications you are NOW taking and for WHAT CONDITIONS they were prescribed.

Have you ever had x-rays taken of your jaw joints in another office or institution?

Yes  No

If "YES", please notify who took the x-ray(s) and have the x-ray(s) sent to our office.

	Check One:	Explain "Yes" answers
Do you wear, or have you ever worn, a splint, bite plate, or dental appliance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been treated for a "bad bite" or malocclusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have extensive dental crowns and bridges?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have missing back teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear a removable partial denture?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been treated for problems of your jaw joint or for facial muscle spasms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever awaken with an awareness of your teeth or jaws?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you aware of clenching your teeth during the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been told that you grind your teeth in your sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your teeth hurt from biting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any pain or soreness around your eyes, ears or other parts of your face?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have "tension" headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have occasional headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever have migraine headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you frequently have stiff neck muscles or neckaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do your jaw muscles become tired frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have difficulty in opening your mouth widely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does any family member or relative have arthritis or gout?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever received a severe blow to the side of the head or jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your jaw get "stuck", "locked", or "go-out"?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had problems with your ears, such as ringing or change of hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever hear grating sounds from your jaw joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you ever hear clicking or popping sounds from your jaw joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel your ears are occasionally "stopped up"?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you presently in any pain from your jaw joints or muscles?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does pain or discomfort from your jaw joints prevent your being able to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there times when you notice that this problem or pain is less or gone completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you afraid your problem is serious?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel you need treatment for this problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a problem with insomnia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you under a great deal of stress? Job, family, social, school, . . . ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take more than one alcoholic drink per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you smoke cigarettes, cigars, or a pipe?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you bite your nails, tongue or lips?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have young children in your care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NOTE:</b> We require that we receive your COMPLETED questionnaire PRIOR to your scheduled appointment time. Your cooperation will help us in arriving at a more accurate diagnosis and more effective treatment of your condition.		
Signature of Patient, Parent, Guardian or Personal Representative		Date