

TMJ HEALTH QUESTIONNAIRE

CHIEF CONCERN _____

DATE OF ONSET _____

PAIN SYMPTOMS

Do you get "tension headaches"?	Y	N	Do you get headaches in the right or left temple areas?	Y	N
Do you ever get "migraine headaches"?	Y	N	Do you get headaches in the back of your head?	Y	N
Do you frequently have neckaches or stiff neck muscles?	Y	N	Do you grind your teeth when asleep?	Y	N
Do you have trouble sleeping soundly?	Y	N	Are your jaws tired when you awaken from sleep?	Y	N
Have your teeth been sore upon awakening?	Y	N	When are your symptoms the worse?	_____	
Does your jaw ache when you chew?	Y	N	Does anything make you feel better?	_____	
Do you have ear pain?	Y	N	_____		
Does your jaw ache when you open wide?	Y	N	Have your wisdom teeth been extracted?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N	Details _____		
What medications, if any, are you taking?	_____				

How often do you take medicine for relief of pain?					
a) Never	b) Weekly to Monthly				
c) Weekly	d) Daily				

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw?	Y	N	Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Any whiplash neck injuries?	Y	N	Details _____		

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal?	Y	N	Do you feel or hear a "clicking", "popping" or "cracking" noise from either jaw joint?	Y	N
Are there any foods you avoid eating?	Y	N	Has your jaw ever locked where you were unable to open or close?	Y	N
Do you ever get dizzy?	Y	N	Do you have difficulty opening wide or yawning?	Y	N
Do you ever feel faint?	Y	N	Have you ever had pain in either jaw joint?	Y	N
Do you feel nauseated (sick)?	Y	N			
Is there a family history of jaw joint (TMJ) problems or headaches?	Y	N			

EAR AND EYE SYMPTOMS

Do you have itchiness or stuffiness in either ear?	Y	N	Do you hear ringing, buzzing or hissing sounds in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N	Do you hear grating noises in ears? (like sand particles rubbing)	Y	N
Do you get pain in, around or behind either eye?	Y	N	Do you wear glasses or contacts?	Y	N
Are there times when your eyesight blurs?	Y	N			

BREATHING

Do you have allergies?	Y	N	Is your nose stuffed when you don't have a cold?	Y	N
Do you have sinus problems?	Y	N			
Do you snore at night?	Y	N			

