GOTTSEGEN ORTHODONTICS

TEMPOROMANDIBULAR JOINT (TMJ) QUESTIONNAIRE

NAME:_____ AGE:_____ DATE:_____

Please answer ALL questions by circling or filling in the correct answer

1. Do you have popping, clicking, or grating noises in your right jaw joint?…… Yes No
   left jaw joint?…… Yes No
2. When did you first notice the noise?_____
3. Has the noise recently become more pronounced? …….. Yes No
   When? _____
4. Do you have pain in or around the right joint? …… Yes No
   left joint? …… Yes No
5. When did you first notice the pain? _____
6. Has the pain recently become more pronounced? …… Yes No
   When? _____
7. Is the pain worse: A.M. _____ At meals _____
   P.M. _____ Variable _____
8. Is the pain: Dull _____ Continuous _____
   Stabbing _____ Intermittent _____
   Throbbing _____ Other _____
9. Does the pain sometimes feel like it is in your ear? …… Yes No
10. Do you think this problem has affected your hearing? …….. Yes No
11. Does your jaw problem interfere with your normal daily activities? …… Yes No
12. Does your jaw problem interfere with sleeping? …….. Yes No
13. Are you taking or have you taken any medication(s) for this problem? …… Yes No
    Explain _____
14. Do you have frequent headaches or neckaches? …… Yes No
15. Have you ever had a severe blow or trauma to the head, neck, or jaw? …… Yes No
    Which area? _____ When? _____
    Explain _____
    _____
16. If yes, are you currently involved in litigation related to the event? …… Yes No
17. Did anything else occur which might be related to the onset of the problem? …….. Yes No
    Explain _____
    _____
18. Do you have difficulty chewing? …… Yes No
    Because of: Pain in joint _____ Limited opening _____ Clicking _____
    Pain in teeth _____ Missing teeth _____ Other _____

OVER→

19. a. What makes the pain worse? _____

b. What makes the pain better? _____

20. Has your mouth ever locked open so that you were unable to close it? ……. Yes No

Explain _____

_____

21. Do you or have you had problems opening your mouth wide? …….. Yes No

Explain _____

_____

22. Please indicate the time sequence in which you became aware of the following problems 1st, 2nd, 3rd, etc. Number only those problems which apply to you.

Pain _____ Noise _____ Limited opening _____ Locking _____ Other _____

23. Which aspects of your problem concern you the most? What is your chief complaint? _____

_____

_____

24. Are you aware of clenching your teeth? …… Yes No

25. Do you grind your teeth? …… Yes No

When? _____

26. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in immediate family, or other stressful events?…….. Yes No

Explain _____

_____

27. Do you think nervous tension seems to affect this problem? ……. Yes No

Explain _____

_____

28. Have you had this problem with other joints, or have you been diagnosed with arthritis? …… Yes No

Explain _____

29. Have you ever had orthodontic treatment? …… Yes No

When? _____ Where? _____

30. Have you had recent dental treatment?

When? _____ Where? _____

Explain _____

_____

31. Have you received previous treatment for this problem? …….. Yes No

Explain _____

_____

32. Do you wish to add to the above information? …….. Yes No

_____

_____