TMJ HEALTH QUESTIONNAIRE

NAME ______________________________ **Date** ____________________

CHIEF COMPLAINT ____

DATE OF ONSET ____

PAIN SYMPTOMS

Question	Y	N
Do you get headaches?	___	___
Do you get migraine headaches?	___	___
Do you have neck aches or stiff neck muscles often?	___	___
Do you have chronic shoulder or back pain?	___	___
Do you have trouble sleeping soundly?	___	___
Are your jaws tired when you awaken?	___	___
Are your teeth sore when you awaken?	___	___
Have your wisdom teeth been extracted?	___	___
Do you get headaches in right or left sides of your head?	___	___
Do you get headaches in the front or back of your head?	___	___
Do you clench your teeth during the day?	___	___
Do you clench your teeth at night?	___	___
Do you grind your teeth when asleep?	___	___

When are your symptoms worse? ____

Does anything you take or do make you feel better? ____

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

TRAUMA OR ACCIDENTS

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

Details

JAW JOINT SYMPTOMS

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

EAR AND EYE SYMPTOMS

Question	Y	N
Do you have any pain in your ears?	___	___
Do you suffer from any loss of hearing?	___	___
Do you have itchiness or stuffiness in either ear?	___	___
Do you hear ringing, buzzing or hissing sounds in either ear?	___	___
Do you wear glasses or contacts lenses?	___	___
Are there times when your eyesight blurs?	___	___
Do you get pain in, around or behind the eyes?	___	___

BREATHING

Question	Y	N
Do you have allergies?	___	___
Do you have sinus problems?	___	___
Do you have snore at night?	___	___
Is your nose stuffed when you don't have a cold?	___	___
Have you been diagnosed with Sleep Apnea?	___	___
Have you had a sleep study done at a Sleep Clinic or Hospital?	___	___

SIGNATURE ______________________________________