TMJ PROBLEM QUESTIONNAIRE

Richard L.Alpert, D.D.S. Leor Lindner, D.M.D.

PLEASE ANSWER ALL QUESTIONS | *DO NOT WRITE IN THIS SPACE*

I. **Name** _____ **Date** _____

Age _____ **Referred by** _____

II. Which of the following do you have?

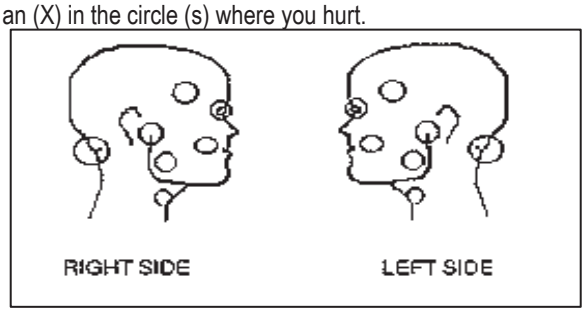
Headaches Neck pain Jaw pain Ear pain

Facial pain Other _____

Which side hurts (circle one) Right Left Both

Comments _____

III. Place an (X) in the circle (s) where you hurt.



Place an (X) on your pain level. (0 = no pain, 10= highest pain)

RIGHT		LEFT
0 1 2 3 4 5 6 7 8 9 10	BEST	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	AVG	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	WORST	0 1 2 3 4 5 6 7 8 9 10

IV. How long have you had this pain? _____

Is this pain constant? Y N

Is the pain (circle all that apply) Aching Burning Stabbing

Other _____

V. Is the pain worse in the (circle all that apply)

Morning Afternoon Evening Night

VI. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply) Jaw Head Neck

(If so, please complete separate Trauma Questionnaires for each trauma or whiplash)

VII. What makes the pain better? _____

What makes the pain worse? _____

What medication(s) do you take or have previously taken for your pain?

MEDICATION DOSE FREQUENCY

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Name: **Date**

VIII. Does it hurt to chew? Y N L R
Does it hurt to open wide? Y N L R
Which side of your jaw makes a popping noise? L R
Which side of your jaw makes a clicking noise? L R
Which side of your jaw makes other noises? L R
What noises?
When did you first notice joint noises?

IX. Has your jaw ever locked? Y N L R
Did it lock open or closed? Open Closed
When did this first happen?
When did this last happen?
Has your jaw ever slipped out of place? Y N L R

X. Have you noticed a change in your bite? Y N
Did you notice a change at your front teeth? Y N
Did you notice a change at your back teeth? Y N
Has your profile changed? Y N
Have you noticed any crookedness or asymmetry in your jaw? Y N
When did you notice the asymmetry?
Other

XI. Are your teeth sore or sensitive? Y N
Do you clench your teeth? Y N
Do you grind your teeth? Y N
Do you do this during the day or night? Day Night
When did you start clenching or grinding?

XII. Do you have problems with your ears? Y N L R
Ringing? Y N L R Dizziness? Y N
Hearing? Y N L R Other

XIII. Is it difficult to swallow? Y N
Is it painful to swallow? Y N
Have you noticed lumps in your face? Y N
Throat? Y N Neck? Y N
Other

XIV. Have you had any prior treatment for your symptoms? Y N
Splint or Night Guard 1 Y N When?
Did it help? Y N
Splint or Night Guard 2 Y N When?
Did it help? Y N
Bite Adjustment? Y N When?
Orthodontics? Y N When?
Did it help? Y N
Surgery? Y N When?
What type and which side?

Did it help? Y N
Explain

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Name: _____ **Date** _____

XIV. Did you **ever** have orthodontics? Y N
What were they treating? _____

Did you have tooth extractions? Y N
If so, which teeth? _____
Did you wear elastics? Y N
Did you wear any type of applianc Y N
If so, what type of applicance (i.e.headgear)? _____

XV. Describe your problems as you understand them: _____

XVI. Reports may be sent to my:
Medical Doctor _____
Dentist _____
Other _____

XVII I have completed the above to the best of my knowledge and I consent to the use of my x-rays, records and photos for scientific publication or teaching providing my name remains anonymous.

_____
Signature
(Parent or Legal Guardian must also sign if the patient is under the age of 18.)

_____
Date