TMJ QUESTIONNAIRE

Temporomandibular disorder health history form for patients.

Wilson & Hendrickson ORTHODONTICS

PATIENT INFORMATION

Date Completed _____

Name _____ Birthdate _____

LAST FIRST MIDDLE MM/DD/YY

What problems do you have with your jaw joints, jaw muscles, and/or teeth? _____

_____

When did these problems start? _____

What do you think caused these problems? _____

MEDICAL INSURANCE INFORMATION

Policy Owner's Name _____ Policy Owner's Address _____

Policy Owner's Phone _____ Relationship to Patient _____

Policy Owner's Birth Date _____ Policy Owner's Employer _____

Insurance Company _____ Phone # _____ Group # _____ ID # _____

SYMPTOMS Please mark each symptom that applies.

JAW JOINT PROBLEMS	LEFT	RIGHT	
Joint clicking or popping	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Grating noises	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Jaw locks open	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Jaw locks closed	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Limited jaw opening	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Jaw does not open smoothly	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Soreness of jaw joints	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Soreness of face muscles	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____

TEETH PROBLEMS	LEFT	RIGHT	
Teeth grinding	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Teeth clinching	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Soreness of one or more teeth	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____
Looseness of one or more teeth	☐ YES ☐ NO	☐ YES ☐ NO	Comments _____

HEAD AND FACIAL PAIN	LEFT	RIGHT	(LEAST) DEGREE OF PAIN (MOST)
Migraine type headache	☐ YES ☐ NO	☐ YES ☐ NO	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Cluster headaches	☐ YES ☐ NO	☐ YES ☐ NO	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Sinus headaches	☐ YES ☐ NO	☐ YES ☐ NO	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Headaches in back of head	☐ YES ☐ NO	☐ YES ☐ NO	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Hair and/or scalp painful to touch	☐ YES ☐ NO	☐ YES ☐ NO	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe where you have pain and where it is the most severe: _____

EAR AND BALANCE PROBLEMS

Pain in ear	☐ YES ☐ NO	Comments _____
Ringing or buzzing	☐ YES ☐ NO	Comments _____
Clogged or stuffy ears	☐ YES ☐ NO	Comments _____
Diminished hearing	☐ YES ☐ NO	Comments _____
Dizziness or vertigo	☐ YES ☐ NO	Comments _____
Poor sense of balance	☐ YES ☐ NO	Comments _____

THROAT PROBLEMS

Swallowing difficulty	☐ YES ☐ NO	Comments _____
Throat tightness	☐ YES ☐ NO	Comments _____
Throat soreness	☐ YES ☐ NO	Comments _____
Laryngitis	☐ YES ☐ NO	Comments _____
Voice fluctuations	☐ YES ☐ NO	Comments _____
Throat congestion	☐ YES ☐ NO	Comments _____
Frequent cough	☐ YES ☐ NO	Comments _____
Frequent throat clearing	☐ YES ☐ NO	Comments _____
Excessive salivation	☐ YES ☐ NO	Comments _____
Tongue pain	☐ YES ☐ NO	Comments _____
Pain in roof of mouth	☐ YES ☐ NO	Comments _____

NECK AND SHOULDER PAIN

Neck, shoulder, or back pain	☐ YES ☐ NO	Comments _____
Neck, shoulder, or back reduced mobility	☐ YES ☐ NO	Comments _____
Frequent neck muscle fatigue	☐ YES ☐ NO	Comments _____
Arm or finger tingling, numbness, or pain	☐ YES ☐ NO	Comments _____

EYE PROBLEMS

Pain around or behind eyes	☐ YES ☐ NO	Comments _____
Bloodshot eyes	☐ YES ☐ NO	Comments _____
Blurred vision	☐ YES ☐ NO	Comments _____
Pressure behind eyes	☐ YES ☐ NO	Comments _____
Light sensitivity	☐ YES ☐ NO	Comments _____
Watering of eyes	☐ YES ☐ NO	Comments _____
Drooping of eyelids	☐ YES ☐ NO	Comments _____

Please describe any recent or childhood history or trauma to the head or face such as falls, auto accident, blows to the head or face, sports injury?

_____

_____

Please describe any frequent activity that causes you to hold your head or neck in an imbalanced position such as playing instruments, keyboarding, holding phone, etc? _____

_____

Have you ever been treated for a TMJ problem before? If so, when? _____ By whom? _____

Was the problem the same or different than your current problem? _____

What treatment did you have? _____ Do you think the treatment was successfull? _____

What would you like your treatment here to achieve? _____