SHENANDOAH
ORAL & FACIAL SURGERY
The Valley's Dental Implant Center

TMJ Questionnaire

Patient Name: _____ Date of Birth:_____ Today's Date:_____

CHIEF COMPLAINT:

- What is the main problem that brings you here?_____
  _____
- Did this problem begin: **SUDDENLY** **GRADUALLY**
- How long have you been bothered by this problem? YEARS MONTHS WEEKS DAYS

PAIN SYMPTOMS:

- Location (please circle all locations that you are having pain. **R** for right, **L** for left)

Joint	□ R	□ L
Ear	□ R	□ L
Upper teeth/jaw	□ R	□ L
Lower teeth/jaw	□ R	□ L
Eyes	□ R	□ L
Face	□ R	□ L
Shoulders	□ R	□ L
Forehead	□ R	□ L
Neck	□ R	□ L

- Headaches (answer only if you have <u>regular</u> headaches)
  - How often? _____
  - Time of Day _____
  - Location: **ONE SIDE** **BOTH SIDES**
  - Previous Diagnosis/Treatment (if applicable): _____

- Circle all the terms that describe your pain:

  SHARP DULL ACHING DEEP SUPERFICIAL BURNING PUSLING SPREADING

- Does anything make the pain better or worse? _____

- Does the pain come and go or is it a constant pain: _____

DYSFUCNTION:

- Do your jaw joints make noises? □ Yes □No

  RIGHT □Clicking □Popping □Grinding □Other:_____

  LEFT □Clicking □Popping □Grinding □Other:_____

- Has your jaw ever locked open? □Yes □No
  If so, when did this first occur?_____
  How often has this occurred? _____

- Has your jaw ever locked closed or partially closed? □Yes □No
  If so, when did this first occur?_____

  How often has this occurred? _____

- Have you ever injured your jaw? □Yes □No
  If so, when did the injury occur and what happened?_____

- Please provide any additional information you feel may be helpful in the diagnosis or treatment of your condition:_____

  _____