Nebraska Institute of Cosmetic Dentistry
TMJ Problem Questionnaire

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

Name _____ Date _____

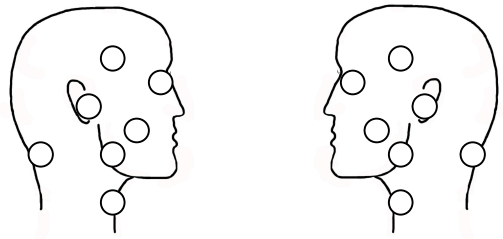
Age_____ Referred By _____

Which of the following do you have? (Check all that apply)
❒ Headaches ❒ Neck Pain ❒ Jaw Pain ❒ Ear Pain
❒ Facial Pain ❒ Other_____

Which Side Hurts? ❒ Both ❒ Right ❒ Left

Comments_____

Darken the circle(s) where you hurt.



Right Side Left Side

How long have you had this pain? _____

Is the pain constant? _____

Is the pain: ❒ Aching ❒ Burning ❒ Stabbing

Other _____

Is the pain the worst in the: check all that apply

❒ Morning ❒ Afternoon ❒ Evening ❒ Night

Have you ever injured or sustained any form of trauma or whiplash to your: ❒ Jaw ❒ Head ❒ Neck

If so, please complete the trauma questionnaire.

What makes the pain better? _____

_____

What makes the pain worse? _____

_____

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

MEDICATION	DOSE	FREQUENCY

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Does it hurt to chew? Yes No

Does it hurt to open wide? Yes No

Which side of your jaw makes a popping noise? Left Right

Which side of your jaw makes a clicking noise? Left Right

Which side of your jaw makes other noises? Left Right

What noises? _____

When did you first notice joint noises? _____

Has your jaw ever locked? Yes No

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? Yes No

Which Side? Left Right

Have you ever noticed a change in your bite? Yes No

Did you notice a change at your front teeth? Yes No

Did you notice a change at your back teeth? Yes No

Has your profile changed? Yes No

Have you noticed any crookedness or asymmetry in your jaw? Yes No

When did you notice the asymmetry? _____

Are your teeth sore or sensitive? Yes No

Do you clench your teeth? Yes No

Do you clench your teeth? Yes No

Do you do this during Day or Night? Day Night

When did you start clenching or grinding? _____

Do you have problems with your ears? Yes No

❒ Dizziness ❒ Ringing ❒ Hearing ❒ Other _____

Is it difficult to swallow? Yes No

Is it painful to swallow? Yes No

Have you noticed lumps in your: ❒ Face ❒ Neck ❒ Throat

Other? _____

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Have you had any prior treatment for TMJ? Yes No

-Splint? Yes No When? _____
Did it help? Yes No

- Nightguard? Yes No When? _____
Did it help? Yes No

- Bite Adjustment? Yes No When? _____
Did it help? Yes No

-Orthodontics? Yes No When? _____
Did it help? Yes No

Other? _____

Describe the problems in your own words as you understand them.

_____

_____

_____

_____

_____

_____

Reports may be sent to my:

❒ Medical Doctor _____

❒ Dentist _____

❒ Other _____

I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing. I consent to the use of my x-rays, records, and photos for scientific publication or teaching providing my name be anonymous.

X _____
Signature

Date _____