

# TMJ Questionnaire

To assist us in diagnosing your condition, please print out and complete the following questionnaire. Bring it with you to your visit.

In your own words, describe your symptoms \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you presently under the care of a physician or have you been in the past year? YES / NO

Physician's Name \_\_\_\_\_  
Condition treated \_\_\_\_\_  
Treatment Recommended \_\_\_\_\_  
Any medications you are taking \_\_\_\_\_

General Dentist's Name \_\_\_\_\_  
Date of last dental appointment \_\_\_\_\_  
Treatment / purpose of appointment \_\_\_\_\_

Do you have any problems with your jaw? YES / NO

Describe \_\_\_\_\_  
\_\_\_\_\_

Have you received treatment for your jaw problems? YES / NO

Who directed this treatment? \_\_\_\_\_

What was the treatment?	Success of treatment		
	Yes	No	(1=good / 2=fair / 3=poor)
Bite Splint	_____	_____	_____
Medication	_____	_____	_____
Physical therapy	_____	_____	_____

Occlusal adjustment	_____	_____
Orthodontics	_____	_____
Counseling	_____	_____
Surgery	_____	_____
Other	_____	_____

Do you do anything to relieve the pain? \_\_\_\_\_

Are you aware of anything that makes the pain worse? \_\_\_\_\_

Do you jaw joints make noises? YES / NO

RIGHT	Clicking_____	Popping_____	Grinding_____
LEFT	Clicking_____	Popping_____	Grinding_____

Has your jaw ever locked open? YES / NO Last time? \_\_\_\_\_

Has your jaw ever locked closed? YES / NO Last time? \_\_\_\_\_

Have you ever injured your jaws? YES / NO

When? \_\_\_\_\_ Please describe the injury \_\_\_\_\_

Do you consider yourself to be under more stress than most people? YES / NO

Please provide any additional information you fee may be helpful it the diagnosis or treatment of your condition. \_\_\_\_\_

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