TEMPOROMANDIBULAR JOINT DIAGNOSTIC QUESTIONNAIRE

DATE: ______________________________

PATIENT'S NAME: ______________________________ AGE: ______________ GENDER: ☐ F ☐ M

DO YOU HAVE CLICKING, POPPING, OR GRATING NOISE IN YOUR RIGHT JAW JOINT?................ ☐ Y ☐ N
LEFT JAW JOINT?.................. ☐ Y ☐ N

WHEN DID YOU FIRST NOTICE THE NOISE? ______________________________

HAS THE NOISE RECENTLY BECOME MORE PRONOUNCED? .... ☐ Y ☐ N

DO YOU HAVE PAIN IN OR AROUND THE RIGHT JAW JOINT? .... ☐ Y ☐ N
LEFT JAW JOINT?.. ☐ Y ☐ N

WHEN DID YOU FIRST NOTICE THE PAIN? ______________________________

HAS THE PAIN RECENTLY BECOME MORE PRONOUNCED? .... ☐ Y ☐ N

THE PAIN IS WORSE DURING... ☐ MORNING ☐ AT MEALS ☐ EVENINGS ☐ NO SPECIFIC TIME

THE PAIN IS: ☐ DULL ☐ CONTINUOUS ☐ STABBING ☐ INTERMITTENT ☐ THROBBING
☐ OTHER: ______________________________

DOES THE PAIN SOMETIMES FEEL LIKE IT IT IN YOUR EAR? .... ☐ Y ☐ N

DO YOU THINK THIS PROBLEM HAS AFFECTED YOUR HEARING? .... ☐ Y ☐ N

DOES YOUR JAW PROBLEM INTERFERE WITH NORMAL ACTIVITIES? .... ☐ Y ☐ N

ARE YOU TAKING ANY MEDICATION FOR THIS PROBLEM? .... ☐ Y ☐ N

IF YES, WHAT MEDICATIONS? ______________________________

DID ANYTHING OCCUR THAT MIGHT BE RELATED TO THE ONSET OF THIS PROBLEM?.................. ☐ Y ☐ N

IF YES, EXPLAIN. ______________________________

DO YOU HAVE DIFFICULTY CHEWING? .... ☐ Y ☐ N

BECAUSE OF: ☐ PAIN IN JOINT ☐ LIMITED OPENING ☐ PAIN IN TEETH ☐ MISSING TEETH ☐ CLICKING
☐ OTHER: ______________________________

HAS YOUR MOUTH EVER LOCKED OPEN AND YOU WERE UNABLE TO CLOSE IT? .... ☐ Y ☐ N

WHEN? ______________________________

PLEASE INDICATE THE TIME SEQUENCE IN WHICH YOU BECAME AWARE IN THE FOLLOWING PROBLEMS. NUMBER ONLY THE ONES THAT HAVE APPLIED TO YOUR PROBLEM. (EXAMPLE: 1 - 1ST, 2 - 2ND, 3 - 3RD ETC)

PAIN #_____ NOISE #_____ LOCKING #_____ CLICKING#_____ OTHER:____________ #_____

WHICH ASPECTS OF YOUR PROBLEMS CONCERN YOU THE MOST? ______________________________

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ARE YOU AWARE IF CLENCH YOUR TEETH? .... ☐ Y ☐ N

DO YOU GRIND YOUR TEETH? ………………………………………………………………………………… ☐ Y ☐ N

HAS THERE BEEN A RECENT LIFESTYLE CHANGE? FOR INSTANCE, MARITAL STATUS, CHILDBIRTH, EMPLOYMENT, DEATH IN IMMEDIATE FAMILY, OR ANY OTHER STRESSFUL EVENTS? …………………… ☐ Y ☐ N

DO YOU THINK NERVOUS TENSION SEEMS TO AFFECT THIS PROBLEM? ………………………………… ☐ Y ☐ N

HAVE YOU HAD PROBLEMS WITH OTHER JOINTS? ………..……………………………………………… ☐ Y ☐ N

HAVE YOU HAD RECENT DENTAL TREATMENT? ………..……………………………………………… ☐ Y ☐ N

HAVE YOU HAD ORTHODONTIC TREATMENT? ………..……………………………………………… ☐ Y ☐ N

WHEN? ______________________ WHERE? ______________

HAVE YOU HAD IMAGING TAKEN FOR THIS PROBLEM? X-RAYS, CAT SCAN, MRI, ARTHROSCOPY?…… ☐ Y ☐ N

WHEN? ______________________ WHERE? ______________

DO YOU WEAR A NIGHT GUARD? ………..……………………………………………………………… ☐ Y ☐ N

HAVE YOU EVER RECEIVED PREVIOUS TREATMENT FOR THIS PROBLEM? IF YES, EXPLAIN.

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OTHER COMMENTS: ______________________________________

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I, ______________________ , HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. IF THERE ARE ANY CHANGES TO THESE HISTORY RECORDS OR MEDICAL/DENTAL STATUS, I WILL INFORM THIS PRACTICE.

SIGNATURE: ______________________________ DATE: ______________