TMJ History Questionnaire

Name:_____ Date of Birth: _____

Address:_____

Phone:_____ Parents Name(if applicable)_____

Occupation: _____

Your **Physician**: _____ Phone: _____

Address: _____

Your **Chiropractor**: _____ Phone: _____

Address: _____

Your **Physiotherapy**: _____ Phone: _____

Address: _____

Do you have dental insurance? (circle one) **YES** **NO**

If yes, Name of company: _____

Person responsible for account: _____

GENERAL HEALTH HISTORY

Have you had any of the following? (Circle all that apply)

Arthritis **Osteoarthritis** **Rheumatoid Arthritis** **Sinus Infection** **Ear Infection**

Swollen Glands **Blood Vessel Disease**

Have you had frequent headaches? (circle one) **YES** **NO**

How long do they last? _____ Date: _____

Migraines? **YES** **NO**

Have you ever had a severe blow to the head or whiplash injury? **YES** **NO**

What part of the head? _____ Date:_____

Have you ever suffered nutritional deficiencies? **YES** **NO**

Do you have ulcers? **YES** **NO**

Do you regularly take any medications? **YES** **NO**

What kinds: _____

Any other current, non-dental, medical issues or diseases: _____

_____

Do you have any emotional problems regarding your teeth or jaws, please describe. _____

_____

Please indicate anything else about yourself that you suspect may be related to your condition. _____

_____

Have there been any recent increases in your stress level? _____

Do you work in the same position for long periods of time? **YES** **NO**

Do you talk on the telephone for long periods of time? **YES** **NO**

CHIEF COMPLAINT

What is the main problem that brings you here? _____

_____

Did this problem begin suddenly or gradually? _____

Date of onset: _____

How long have your been bothered by this problem? Years _____ Month_____

Area of onset? _____

Do symptoms affect one or both sides? **Right** **Left** **Both**

PAIN SYMPTOMS

Do you have pain in the following areas (circle right or left side)

Joint		R	L	Eyes	R	L
Base of skull		R	L	Forehead	R	L
Ear	inside of ear	R	L	Neck	R	L
	In front of ear	R	L	Shoulder	R	L
	Ear lobes tender swollen	R	L	Shoulder Blade	R	L
Upper teeth or jaw		R	L	Arms	R	L
Lower teeth or jaw		R	L	**Does rising arm cause pain?**		
Tongue		R	L	Fingers	R	L
Facial muscles		R	L	Chest	R	L
				Upper Back	R	L
				Middle Back	R	L
				Lower Back	R	L

Type of pain felt? (Circle all that apply)

Piercing **Paroxysmal** **Dull Superficial Deep**

Quality of pain? (Circle all that apply)

Burning **Aching** **Sharp**

Frequency: _____

Duration – Is the pain constant? Intermittent? _____

Does the pain last for… **Moment** **Minutes** **Hours** **All Day** **Longer**

Does the pain… **Stay the same** **Increase/Decrease** **Remain the same**

Does the pain start… **Suddenly** **Gradually**

Does the pain stop… **Suddenly** **Gradually**

The period of greatest intensity…What time of day or night is the pain most severe? _____

How often do you have pain? _____

Do you know anything that triggers the pain? _____

How often are you pain free? _____

What is the longest pain-free period you have? _____

What medications, if any, do you take to relieve pain? _____

Does rest increase or decrease the pain? _____

Please describe any method of positioning the jaw or head that you have found for relieving the pain. _____

_____

Do any of the following activities cause pain? (Circle all that apply)

Yawning **Chewing** **Swallowing** **Speaking** **Singing** **Shouting** **Brushing Teeth**

Moving Head **Moving Neck** **Moving Shoulders** **Moving Arms**

Did the symptoms start after any of the following conditions? (Circle all that apply)

Severe emotional upset **Excessively large bite or yawn** **Blow to jaw**

Irregular or raised dental filling **Excessive opening of mouth during dental extraction**

Traction for cervical arthritis

ASSOCIATED COMPLAINTS

Dysfunction

Do you have difficulty in opening your mouth **Normally** **Partially** **Almost not at all**

Do you have difficulty in closing your mouth **Normally** **Partially** **Almost not at all**

Do you ever open so wide that your mouth locks open? **Yes** **No**

Does opening or closing your mouth cause facial pain? **Yes** **No**

Do you hear any of these sounds in the joint?

Grating	R	L	**How Often?**	Constant	Occasionally	Frequently
Clicking	R	L	**How Often?**	Constant	Occasionally	Frequently
Snapping	R	L	**How Often?**	Constant	Occasionally	Frequently
Popping	R	L	**How Often?**	Constant	Occasionally	Frequently

Have you noticed any change in your bite? **Yes** **No**

Any change in your ability to chew? **Yes** **No**

Oral Symptoms

Are your jaws clenched or teeth sore when you awaken from sleep? **Yes** **No**

Do you clench or grind your teeth when asleep? **Yes** **No**

Do you clench or grind your teeth during moments of concentration? **Yes** **No**

Driving **Gardening** **Bowling** **Golfing** **Watching TV**
Other: _____

Do you chew gum? **Yes** **No**

How do you chew your food? **Comfortably** **Angrily** **To get it down**

Are your jaw muscles ever tired? **Yes** **No** When? _____

Do you ever notice extreme warmth in your jaw muscles? **Yes** **No**

When? _____

Have you ever noticed production of more or less saliva in your mouth? **Yes** **No**

Do you have gingival bleeding or swelling of the gums? **Yes** **No**

Do you have any of the following tastes in your mouth? **Salty** **Copper** **Sour or Lemon**

Do tears form in your eyes for no apparent reason? **Yes** **No**

Do you ever feel pressure or tenderness about your eyes? **Right** **Left**

Does your face swell? **Yes** **No** what part and when? _____

Do you have dizziness? **Yes** **No** When and frequency? _____

Do you ever feel faint? **Yes** **No**

Do you ever have any troubles swallowing? **Yes** **No**

Are your teeth sensitive to cold? **Yes** **No**

Miscellaneous

Ear Symptoms – Do you have:

Tinnitus (ringing in the ear) R L

Popping or whoosing noises on opening or closing of your jaw? R L

Stuffiness R L

Changes in hearing ability? R L

Do you have a jaw thrust habit or nervous twitch about the face? **Yes** **No**

When: _____ Where: _____

Does anyone else in your family have similar problems? **Yes** **No**

If yes explain: _____

Have you ever had your teeth straightened? **Yes** **No**

Have you ever had you bit adjusted by your dentist? **Yes** **No**

Have you ever had treatment for facial pain? **Yes** **No**

What were the results? _____

Have you had cortisone injections in your face or jaw? **Yes** **No**

Are you sensitive to metal rings or earrings? **Yes** **No**

Please describe briefly any changes in location or character of symptoms since this problem began _____

_____

Is there anything else you wish to tell us which you feel would help us better understand your problem. _____

_____

I hereby authorize Dr. Ross, Dr. Donatelli or Dr. Filo to contact my physician if required to update the medical records for myself and/or my children and/or my dependents.

Signature _____

Date _____