HealthPARK

General Dentistry & Dental Specialists

110 S. Tippecanoe Dr., Tipp City, OH 45371
(937) 667-2417 www.healthparkdentistry.com

TMJ Questionnaire

Patient Name: ____ Date: ____________
Last, First MI (Preferred Name)

Address: ____
Street Apartment #

____

Phone (Home): ____________________________ (Work): ____________ Ext: ______________
Cell Phone: __________________________ Email: ____________________________________
City State Zip Code

Occupation ____________________________________ Referred by __________________________
Family Dentist ___________________________Family Physician ______________________________
Please list any physicians, osteopaths, dentists, neurologists, chiropractors, psychiatrists, etc. who have tried to help you for your head and neck problem and what they found and recommended.

Dr. ____ Telephone __________________
Address ____
Diagnosis, & treatment ____
____

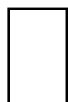
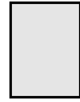
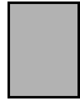
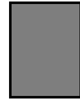
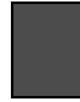
Dr. ____ Telephone __________________
Address ____
Diagnosis, & treatment ____
____

Did any of the above doctors' treatment make you feel better ____________________________________
Worse ____

1. How were you referred to HealthPark Dentistry____
____

2. Please describe your chief problem ____
____

3. Please mark on a scale of 0-10 with 0 being no pain, & 10 being the worst possible pain, what your level of pain is ..

0	1-2	3-4	5-6	7-8	9-10
No Pain	Mild Pain	Discomforting	Distressing	Intense	Excruciating

4. How many hours in an average day will you experience this pain?
How long does it last: Minutes ________, Hours _______, All Day ________, Days ________.
How many hours per day ______________, How many days at a time _______________
5. Has your doctor said you have migraines____
6. Does the pain interfere with your work or other activities___________________________________.
____

7. Does the pain interfere with your sleep____
8. How long have you had this problem?____
9. What medications do you take for pain____
How much per month ______________________________________
10. The pain and/or clicking in and around your jaw joints: which side ______________. Do you notice it upon waking __________, during eating _________, when yawning _____________.
How long ago did you first notice it____
Does it come and go or hurt all the time ____
11. Have you ever had jaw surgery? Yes ________ No __________
12. Previous/current psychological counseling? ____
13. When did your symptoms first start ____
Have the symptoms become worse ____
What caused the problem ____
14. Was it related to severe emotional upset _________________, Opening very wide _____________,
Blow to jaw ____________________________, Dental treatment ____________________________,
Holding open for long periods of time ____________________, Traction _______________________,
Braces ___________________________, Injury ____.
15. In your opinion, what do you think should be done to solve your problem? ____________________
____
16. Have you been involved in any accident that you think might be related? If so, describe the accident and the date ed to your problem?____
17.a. If you had a jaw injury that contributed to your problems, on a scale of 1-10 with 1 being almost none, how much has your injury contributed to your problem?______________________________

b. Are you receiving any compensation or disability for your TMJ problem? ___________________

c. Are you now, or are you considering litigation related to your TMJ problem? _______________

18. Please indicate anything else able yourself that you feel may be related to your condition?
____

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19. Do you have difficulty opening your mouth wide __________. How long have you had this problem
____
20. Are you aware of clenching or grinding your teeth ___________. day or night ________________
Mild _____, Moderate ______, or Severe ______. How long have you been doing this _____________
21. Do you have any of the following habits:
( ) Telephone/shoulder Position ( ) Gum Chewer ( ) Pipe Stem Biter ( ) Chew Tobacco
22. On a scale of 1-10 with 10 being the most stressful, how stressful is your job?_________________
Most stressful situations? ____
____
23. Does your bite feel uncomfortable to you __________. How does it bother you _______________
____
24. Does it hurt when you chew or do your jaws get tired at mealtime____________________________
25. Are your jaws clenched when you awaken ______. Do you grind your teeth when asleep _________
Awake _________, Driving __________, Working ___________, Playing sports ___________, When concentrating ________, Other times _________________.
26. Has there ever been a time when your jaw locked or had a catch when you tried to open
____
27. Is your discomfort worse in the am _________, pm ______, Made worse by ___________________,
Made better by ________________________________. What is the longest period in the last month you have gone without pain ____
28. Please indicate any ear problems: Ringing - Right, Left ________, Popping- Right, Left _________,
Pain- Right, Left --_______, Itching- Right, Left ________, Hearing changes- Right, Left ____________
29. Does your neck ever make clicking, grating, or popping noises on movement __________________
30. Does it hurt when you turn or bend your neck ____

31. Have you ever had your neck in traction or worn in a cervical collar ___________________________
32. Does your head or neck ever get momentarily stuck in one position ____________________________
33. Does any part of your head or neck feel numb or burning ______________________________________
34. Do you have pain, tingling, or numbness in your arms, hands, or fingers _________________________

35. Do you sleep on your back, side or stomach _________. Do you have hands or arms around your head as you sleep _________. How many pillows do you use ___________.
36. Do you have problems with insomnia ________. how many hours sleep do you get per night________
37. Do you sleep with your mouth open _________________________
38. Do you use alcohol or sleeping pills to fall asleep ____
39. Do you play a musical instrument _____ what kind ____
40. Do you have any sore or sensitive teeth? ____
41. What sports do you play? ____
42. Please describe any non-dental current physical problems _____________________________________
____
43. Have you recently had an operation with a general anesthetic __________________________________
44. Do you have sinus infections _________. If so, do they hurt more when you lean over___________
45. Do you have a jaw thrust habit ____
46. Do you have a nervous twitch about your face (tic) ____
47. Do you ever rest your tongue between your teeth to avoid biting your teeth together _____, Bite your lips, cheeks, nails, or other objects ____
48. Do you get low back pain _________, how often ____
49. Do you have any children __________. What ages ____
50. Cranial nerves
  a. Have you noticed a change in your taste or smell ____
  b. Have you noticed blurred or double vision ____
  c. Have you noticed your eye moving involuntarily, rhythmically _______________________________

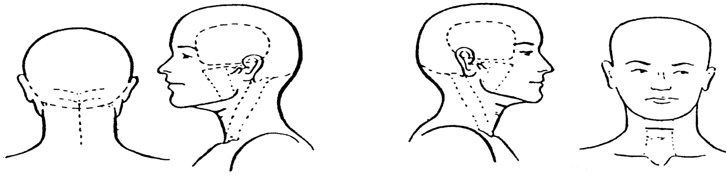
51. Do you:	No	Occasionally	Frequently
Snore while sleeping?	_____	_____	_____
Gasp while sleeping?	_____	_____	_____
Feel tired upon awakening?	_____	_____	_____
Have difficulty staying awake during the day?	_____	_____	_____
Read or watch TV in bed?	_____	_____	_____

Personal History

Can you diagram a normal day's pain cycle: please note on the diagram when you
A. Wake B. Go to work C. Come home from work D. Go to bed

	6 a.m.	12 noon	6 p.m.	12 midnight
Severe				
Moderate				
Mild				
None				

Please color in all the areas where you experience pain on these pictures:



Chief Complaints according to severity:
1. ___
2. ___
3. ___
4. ___

Please list any vitamins or minerals you regularly take. Specify amount.___
___
Please describe any regular exercise you do ___
___

Please list what you had for breakfast today ___
___

Nutritional History

Do you usually eat	Yes	No		**How often do you have**	3x daily	Daily	3x week	3x month	Never
Breakfast				Milk					
Lunch				Coffee					
Dinner				Decaf coffee					
Between Meals				Refined sugar					
Before Bed				White bread					
				Soft drinks					

Self Evaluation Form

1. Do you characterize yourself as depressed? 1 2 3 4 5
   mild moderate severe
2. Do you characterize yourself as being anxious or tense? 1 2 3 4 5
   mild moderate severe

3. Have you experienced stressful situations over the past year? 1 2 3 4 5
   few some many