TMJ HEALTH QUESTIONNAIRE

NAME ________________________________ DATE ___________

PAIN SYMPTOMS

_ Do you get headaches?_  _ Do you get headaches in right or left sides of your head?
_ Do you get migraines?_  _ Do you get headaches in the front or back of your head?
_ Do you have neck aches or stiff neck muscles often?_  _ Do you clench your teeth during the day?
_ Do you have chronic shoulder or back pain?_  _ Do you clench your teeth at night?
_ Do you have trouble sleeping soundly?_  _ Do you grind your teeth when asleep?
_ Are your jaws tired when you awaken?_  _ Are your teeth sore when you awaken?
_ Are your teeth sore when you awaken?_  _ Have your wisdom teeth been extracted?
_ Have your wisdom teeth been extracted?

When are your symptoms worse? ______________________________________________________

Does anything you take or do make you feel better? ________________________________________


TRAUMA OR ACCIDENTS

_ Have you ever had a severe blow to the head or jaw?_  _ Have you ever been involved in any serious accidents, such as a car accident?
_ Any whiplash or neck injuries?_  

JAW JOINT SYMPTOMS

_ Does your jaw feel tired after a big meal?_  _ Do you feel or hear a ‘clicking’, ‘popping’, or ‘cracking’ noise from either jaw joint?
_ Are there any foods you avoid eating?_  _ Has your jaw ever locked when you were unable to open or close?
_ Do you ever get dizzy?_  _ Do you have difficulty opening wide or yawning?
_ Do you ever feel faint?_  _ Have you ever had pain in either jaw joint?
_ Do you ever feel nauseated (sick)?_  _ Does your jaw ache when you open wide?
_ Is there a family history of jaw joint (TMJ) problems or headaches?_ 

EAR AND EYE SYMPTOMS

_ Do you have any pain in your ears?_  _ Do you wear glasses or contact lenses?
_ Do you suffer from any loss of hearing?_  _ Are there times when your eyesight blurs?
_ Do you have itchiness or stuffiness in either ear?_  _ Do you get pain in, around, or behind the eye?
_ Do you hear ringing, buzzing, or hissing sounds either ear?_ 

BREATHING

_ Do you have allergies?_  _ Is your nose stuffed when you don’t have a cold?
_ Do you have sinus problems?_  _ Have you been diagnosed with Sleep Apnea?
_ Do you snore at night?_ 
_ Have you had a sleep study done at a Sleep Clinic or Hospital?

SIGNATURE ________________________________