ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES OF CHESTER COUNTY, LTD.

TMJ QUESTIONNAIRE

Patient Name_____ Acct. #_____ Date_____

Referred by Dr._____

Do you have?

	Yes	No		Yes	No		Yes	No
Headaches?			Neck Pain?			Jaw Pain?		
Ear Pain?			Face Pain?			Eye Pain?		

Other?_____ Which side hurts? _____Left? _____ Right? _____Both?

Is the pain constant? _____ Aching? _____ Shooting?_____

Worse in the afternoon?_____ Worse in the morning?_____

Does it hurt to chew?_____ Open wide?_____

Does your jaw make a popping noise?_____ Clicking?_____ Grinding?_____

Other?_____

Has your jaw ever "locked" or slipped out of place ?_____

Do you ever clench or grind your teeth?_____

During the day?_____ At night?_____

Do you have problems with your ears?_____ Hearing?_____

Dizziness?_____ Other?_____

Is it difficult to swallow?_____ Painful?_____

Are your teeth sore or sensitive?_____

Are you taking medicine of any kind?_____ What for?_____

In the event that you have had other treatment or other diagnostic studies (x-rays, arthrograms, or MRI) please write a narrative detailing the initial or first symptoms, when they developed, what forms of treatment you have had done (splints, or medication), the results of this treatment, how your symptoms have changed, and a description of the level

of impairment this problem has produced for you (in other words what this problem keeps you from being able to do).

Describe your problem in your own words.