TMJ History Questionnaire

Name ___________________________________________ Age _____ Sex _____ Date _____

1. Do you have noises in either jaw joint? Right jaw joint? YES NO
   [ ] Clicking [ ] Popping [ ] Grating [ ] Crackling [ ] Other _____________________________
   Left jaw joint? YES NO
   [ ] Clicking [ ] Popping [ ] Grating [ ] Crackling [ ] Other _____________________________

2. When did you first notice the noise? __________________________________________

3. Has the noise changed recently in any way? YES NO
   If yes, please describe how and when: ____________________________________________
   __________________________________________

4. Do you have pain in or around either jaw joint? Right jaw joint? YES NO
   Left jaw joint? YES NO
   If yes, please describe in detail: _________________________________________________
   __________________________________________

5. When did you first notice the pain? ____________________________________________

6. Has the pain changed recently in any way? YES NO
   Please describe how and when: _________________________________________________
   __________________________________________

7. Rate the pain at the following times on a scale of 0 (none) to 10 (terrible):
   Morning _____ Afternoon _____ Evening _____ Sleeping _____
   At meals _____ Talking _____ Wide Opening _____ Other _____

8. Does the problem involve your ears? Check all that apply:
   [ ] Ear Pain [ ] Ear popping [ ] Ringing in the ear [ ] Hearing problems [ ] Other _________
9. Does your jaw problem interfere with your normal activities?  
   YES  NO
   If yes, please describe how and why: ________________________________
   ________________________________________________________________

10. What medications are you taking or have taken for this problem? ________________
    ________________________________________________________________

11. Did anything ever happen (facial trauma, unusual opening or biting, dental work/surgery, intubation, motor vehicle accident, neck or back injury, etc.) prior to this problem? _______________________
    ________________________________________________________________
    ________________________________________________________________

12. Do you have problems with jaw movement / function? Check all that apply:
    [ ] Unable to open wide  [ ] Unable to close completely  [ ] Problems moving to sides R / L
    [ ] Locking  [ ] Chewing  [ ] Bite feels “off”  [ ] Grinding  [ ] Clenching  [ ] Sore Teeth

13. How often do you have headaches and when do you get them? _______________________
    ________________________________________________________________

14. Do you have any other joint problems?  
   YES  NO
   If yes, please describe: ____________________________________________
   ________________________________________________________________

15. Do you have back, neck, or postural problems?  
   YES  NO
   If yes, please describe: ____________________________________________
   ________________________________________________________________

16. Have you ever had orthodontic treatment?  
   YES  NO
   If yes, please describe: ____________________________________________
   ________________________________________________________________

17. Have you ever had a bite equilibration or occlusal / bite adjustment?  
   YES  NO
   If yes, please describe: ____________________________________________
   ________________________________________________________________

18. Please tell us anything else that comes to mind concerning any issues that may be related. ________
    ________________________________________________________________
    ________________________________________________________________