

Patient Name: _____

Date: _____

QUESTIONNAIRE FOR PATIENTS WITH TMJ DISORDERS/ FACIAL PAIN

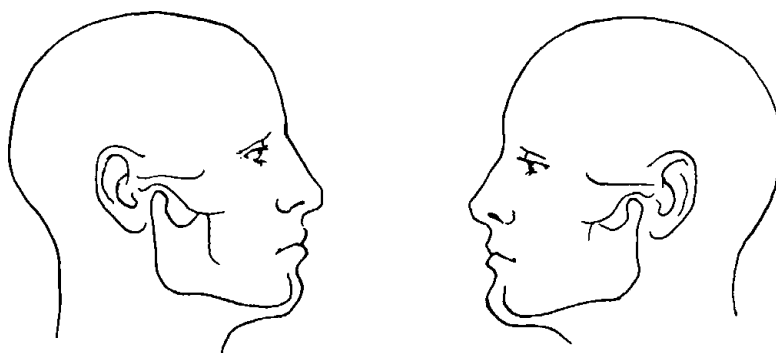
PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

Describe your problem: _____

Which side hurts? Right _____ Left _____ Both _____

For how long? _____

On the figures below please outline where your pain is:



How often do you have pain? _____

Is the pain : Constant ? Intermittent? Sharp? Dull? Throbbing? (circle)

Does it hurt to move your jaw Yes No

Is the pain worse in morning, afternoon, evening? _____

Do you have pain when you awake in the morning? Yes No

If yes, does it get better or worse as the day progresses? _____

Please rate your "typical" level of pain on the following scale:

0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Worst pain imaginable

Do you have noises in your temporomandibular joint(s): Right side Left side

If yes, circle: POP CLICK GRATING/ GRINDING Other _____

When? _____ For how long? _____

Does the pain become worse when there is a clicking or popping sound? Yes No

How long does this last? _____

Has your jaw ever locked open? _____ Closed? _____

When? _____ How often? _____

If your jaw does not make noise or lock now, has it ever in the past?

Describe: _____

Do you have difficulty opening your mouth completely? Yes No

Do you grind or clench your teeth? Yes No -At night _____ During the day _____

Do you have sore or sensitive teeth? _____

Do you have trouble getting to sleep? _____

Do you sleep well? _____

Does the pain ever wake you at night? Yes No

Was the onset of pain: SUDDEN or GRADUAL (circle)

Do you consider yourself to be under a lot of stress? _____

Are you nervous or anxious about anything? _____

Have you ever had a nervous stomach, ulcers, skin disease? _____

Do you have or have you ever had arthritis? _____

Can you remember any injury to your jaw? Yes No

 If yes, describe: _____

Do you have?

 a. Headaches _____

 b. Neckaches _____

 c. Shoulder pain _____

 d. Ear pain _____

 e. Ringing in the ears _____

 f. Dizziness _____

 g. Change in hearing _____

Do you take medications for the pain? Yes No

 If yes, what? _____

Do you take medications for relaxation? Yes No

 If yes, what? _____

Have you had any treatments for your problem? Yes No

 If yes, what kind?

 a. Bite splint _____

 b. Medication _____

 c. Physical therapy _____

 d. Counseling _____

 e. Occlusal adjustment _____

 f. Orthodontics _____

 g. Surgery _____

 h. Other _____

What makes the pain better? _____

What makes the pain worse? _____

Does your pain keep you from doing anything? _____

Any other comments: _____

Thank you for your cooperation.