Marianne Schaefer, D.D.S.

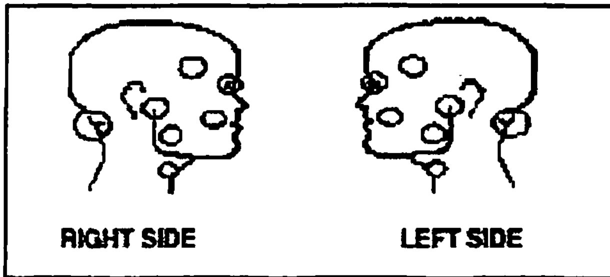
TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

I. Name ______________________ Age ______________
Date __________ Referred by ______________________

II. Which of the following do you have (circle all that apply)
Headaches Neck pain Jaw pain Ear pain
Facial pain Other ______________________
Which side hurts (circle one) Right Left Both
Comments ______________________

III. Place an (X) in the circle (s) where you hurt.



IV. How long have you had this pain? ______________________
Is the pain constant? ______________________
Is the pain (circle all that apply) Aching Burning
Stabbing Other ______________________

V. Is the pain the worst in the (circle all that apply)
Morning Afternoon Evening Night

VI. Have you ever injured or sustained any form of trauma or whiplash to your (circle all that apply)
Jaw Head Neck
(If so, please complete the trauma questionnaire)

VII. ______________________ What makes the pain better?
____
____

What makes the pain worse? ______________________
____
____

What medication(s) do you take or have you previously taken for your pain?

MEDICATION	DOSE	FREQUENCY

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Your Name:

PLEASE ANSWER ALL QUESTIONS			DO NOT WRITE IN THIS SPACE
VIII. Does it hurt to chew?	Y	N	
Does it hurt to open wide?	Y	N	
Which side of your jaw makes a popping noise?	L	R	
Which side of your jaw makes a clicking noise?	L	R	
Which side of your jaw makes other noises?	L	R	
What noises? ______			
When did you first notice joint noises? ______			
IX. Has your jaw ever locked?	Y	N	
Did it lock open or closed? (circle one)	Open	Closed	
When did this first happen? ______			
When did this last happen? ______			
Has your jaw ever slipped out of place?	Y	N	
Which side?	R	L	
X. Have you noticed a change in your bite?	Y	N	
Did you notice a change at your front teeth?	Y	N	
Did you notice a change at your back teeth?	Y	N	
Has your profile changed?	Y	N	
Have you noticed any crookedness or asymmetry in your jaw?	Y	N	
When did you notice the asymmetry? ______			
XI. Are your teeth sore or sensitive?	Y	N	
Do you clench your teeth?	Y	N	
Do you grind your teeth?	Y	N	
Do you do this during the day or night?	Day	Night	
When did you start clenching or grinding? ______			
XII. Do you have problems with your ears? ______			
Dizziness? Y N Ringing Y N			
Hearing? Y N Other? ______			
XIII. Is it difficult to swallow?	Y	N	
Is it painful to swallow?	Y	N	
Have you noticed lumps in your face?	Y	N	
Throat? Y N Neck? Y N			
Other? ______			

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Your Name:

PLEASE ANSWER ALL QUESTIONS	DO NOT WRITE IN THIS SPACE

XIV. Have you had any prior treatment for TMJ? Y N

Splint?	Y	N	When? ______
Did it help	Y	N	
Nightguard?	Y	N	When? ______
Did it help	Y	N	
Bite Adjustment	Y	N	When? ______
Did it help	Y	N	
Orthodontics?	Y	N	When? ______
Did it help?	Y	N	

Other? ______

XV. Describe the problems in your own words as you understand them: ______

______

______

______

______

______

XVI. Reports may be sent to my:

Medical doctor ______

Dentist ______

Other ______

XV. I have completed the above to the best of my knowledge and I personally have filled in each blank in my own writing. I consent to the use of my x-rays, records and photos for Scientific publication or teaching providing my name remains anonymous.

______

Signature

______

Date