About Face Orthodontics | Dental Care

TMJ HEALTH QUESTIONNAIRE

Name ______________________ **Date** ____________________________

CHIEF CONCERN ____

DATE OF ONSET ____

PAIN SYMPTOMS

Do you get headaches? Y N

Do you get migraine headaches? Y N

Do you frequently have neck aches or stiff neck muscles? Y N

Have you ever had chronic shoulder or back pain? Y N

Do you have trouble sleeping soundly? Y N

Are your jaws tired when you awaken? Y N

Are your teeth sore when you awaken? Y N

Have your wisdom teeth been extracted? Y N

What medications, if any, are you taking?

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Do you get headaches in the right or left temple areas? Y N

Do you get headaches in the front or back of your head? Y N

Do you clench your teeth during the day? Y N

Do you clench your teeth at night? Y N

Do you grind your teeth when asleep? Y N

When are your pain symptoms the worst?

____

Does anything make you feel better?

____

How often do you take medication for relief of pain?

____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N

Any whiplash neck injuries? Y N

Have you ever been involved in any serious accidents, such as a car accident? Y N

Details ____

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JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N

Are there any foods you avoid eating? Y N

Do you ever get dizzy? Y N

Do you ever feel faint? Y N

Do you ever feel nauseated? Y N

Is there a family history or jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a 'clicking,' 'popping' or 'cracking' noise from either jaw point? Y N

Has your jaw ever locked where you were unable to open or close? Y N Y N

Do you have difficulty opening wide or yawning? Y N

Have you ever had pain in either jaw joint? Y N

Does your jaw ache when you open wide? Y N

EAR AND EYE SYMPTOMS

Do you have pain in either ear? Y N

Do you suffer from any loss of hearing? Y N

Do you have itchiness or stuffiness in either ear? Y N

Do you hear ringing, buzzing, or hissing sounds in either ear? Y N

Do you wear glasses or contacts? Y N

Are there times when your eyesight blurs? Y N

Do you get pain in, around, or behind either eye? Y N

BREATHING

Do you have allergies? Y N

Do you have sinus problems? Y N

Do you snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N

Have you been diagnosed with Sleep Apnea? Y N

Have you had a sleep study done at a Sleep Clinic (hospital)? Y N