# TMJ QUESTIONNAIRE

Form 401E

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible Please sign each page.

## PATIENT INFORMATION

TODAY'S DATE: _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL _____

RESPONSIBLE PARTY _____

PHYSICIAN NAME & ADDRESS _____

_____ REFERRED BY: _____

## WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

**Frequency:**
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

**Intensity:**
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

| Number | | Frequency | Intensity |
|---|---|---|---|
| *#1 = the most severe symptom* | | 1-4 | 0-10 |
| ____ | Back Pain | ____ | ____ |
| ____ | Dizziness | ____ | ____ |
| ____ | Ear Congestion | ____ | ____ |
| ____ | Ear Pain | ____ | ____ |
| ____ | Eye Pain | ____ | ____ |
| ____ | Facial Pain | ____ | ____ |
| ____ | Fatigue | ____ | ____ |
| ____ | Headaches | ____ | ____ |
| ____ | Jaw Clicking | ____ | ____ |
| ____ | Jaw Joint Noises | ____ | ____ |
| ____ | Jaw Locking | ____ | ____ |
| ____ | Jaw Pain | ____ | ____ |
| ____ | Limited Mouth Opening | ____ | ____ |
| ____ | Muscle Soreness | ____ | ____ |
| ____ | Muscle Twitching | ____ | ____ |
| ____ | Neck Pain | ____ | ____ |
| ____ | Pain when Chewing | ____ | ____ |
| ____ | Ringing in the Ears | ____ | ____ |
| ____ | Shoulder Pain | ____ | ____ |
| ____ | Sinus Congestion | ____ | ____ |
| ____ | Throat Pain | ____ | ____ |
| ____ | Visual Disturbances | ____ | ____ |
| *Other - write in:* | ____ _____ | ____ | ____ |

## LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:
_____
_____
_____
_____

Patient Signature _____ Date _____

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## LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Blood thinners
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle relaxants
Y ☐ N ☐ Pain medication
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs

Other current medications: _____

## MEDICAL HISTORY

Y ☐ N ☐ Anemia
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Blood pressure ☐ High ☐ Low
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Difficulty concentrating
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Fibromyalgia
Y ☐ N ☐ Frequent snoring
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Immune system disorder
Y ☐ N ☐ Injury to ☐ Face ☐ Neck ☐ Teeth ☐ Head ☐ Mouth
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Meniere's disease
Y ☐ N ☐ Migraines
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Needing extra pillows to help breathing at night
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Prior orthodontic treatment
Y ☐ N ☐ Radiation treatment
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Rheumatoid arthritis
Y ☐ N ☐ Scarlet fever
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Sleep Apnea
Y ☐ N ☐ Speech difficulties
Y ☐ N ☐ Swollen, stiff or painful joints
Y ☐ N ☐ Teeth clenching or grinding
Y ☐ N ☐ Wisdom teeth extraction

Other medical history:
_____
_____

## SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

| HEAD PAIN | LOCATION | SEVERITY: MILD | SEVERITY: MODERATE | SEVERITY: SEVERE | FREQUENCY: OCCASIONAL (MONTHLY OR LESS) | FREQUENCY: FREQUENT (WEEKLY) | FREQUENCY: CONSTANT (EVERY DAY) | DURATION: SECONDS | DURATION: MINUTES | DURATION: HOURS | DURATION: DAYS | DURATION: WEEKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| L R B | Front of your head (Frontal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B | Entire head (Generalized) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B | Top of your head (Parietal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B | Back of your head (Occipital) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B | In your temples (Temporal) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y ☐ N ☐ Motor vehicle accident
Y ☐ N ☐ Motorcycle accident
Y ☐ N ☐ Work related incident
Y ☐ N ☐ Playground incident
Y ☐ N ☐ Athletic endeavor
Y ☐ N ☐ Fight
Y ☐ N ☐ Fall
Y ☐ N ☐ Accident
Y ☐ N ☐ Illness
Y ☐ N ☐ Injury
Y ☐ N ☐ Unknown

If accident, what was the date? _____

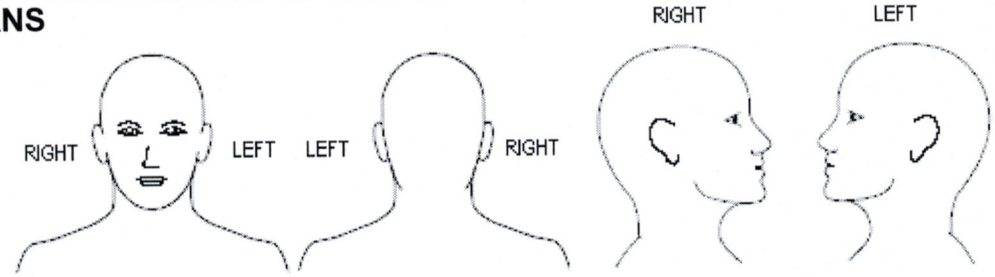
What other information is important to your pain or condition? _____

_____

## DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN |||||||
MODERATE PAIN ^^^^
SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating




I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____

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