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FACIAL PAIN/TEMPOROMANDIBULAR JOINT QUESTIONNAIRE

Once the questionnaire is returned to the office we will gladly arrange a consultation appointment regarding your condition. Please take the time to answer this questionnaire carefully as it is important to help better diagnose and manage your condition.

Please note there is a CONSULTATION FEE and a possible XRAY FEE.
These fees are payable at the time of visit and are not usually covered by dental or medical plans.

Name:____________________Age:_________D.O.B_______Telephone_________________

Address:________________________City:_______________Postal Code:_______________

Referred by:______________________________
Others who are or have been treating this problem
Doctor:__________________________________
Doctor:__________________________________

PLEASE CIRCLE APPLICABLE ANSWERS:

1. Your problem is in your; ear/ jaw/ jaw-joint/ face/ teeth/ neck/ eye/ back of head
   other______________________________

2. When did you first notice this problem?____

3. It is located in the right/ left /both sides?
   Describe location ____

4. Would you call it pain / simple concern / suffering
   other (describe)____

5. Record the level of your pain on this scale.
   mild 1 2 3 4 5 6 7 8 9 10 worst

6. yes no Does pain or discomfort interfere with daily activities?

7. yes no Is this pain constant?

8. yes no Intermittent pain?

9. yes no Burning pain?

10. yes no Dull, aching pain?

11. yes no Stabbing, severe pain?

12. yes no Electrical, shooting pain?

13. yes no Does it hurt when you chew? Where?________________________________

14. yes no Does it hurt to open wide?

15. yes no Do you have joint sounds? Describe_________________________________

16. yes no Have you been able to relieve or diminish the symptoms?
Circle: rest / heat / medication / splint / other__________________________

17. yes no Does anything make your pain worse?
Circle: eating / yawning / talking / weather.

18. yes no Do you have headaches?

19. yes no Does time of day affect the condition?
Circle: morning / evening / sleeping / mealtime.

20. yes no Do you have jaw habits?
Circle: grinding / clenching / testing jaw / biting fingernails
other____

21. yes no Do you have chronic; back / neck / shoulder pain?

22. yes no Do you notice any of the following?

__Hearing loss	right / left
__Pain in teeth in a.m.	right / left
__Headaches	right / left
__Neck Pains	right / left
__Popping, clicking, grinding noise	right / left
__Stuffiness in ears	right / left
__Ringing in ears	right / left
__Dizziness	right / left
__Swallowing problems	right / left
__Locking open	right / left
__Locking closed	right / left

23. yes no Do you recall any jaw trauma such as an accident?
Describe:____

24. yes no Have you ever had any “Whiplash”? When___________________________

26. yes no Have you had jaw surgery ? Describe_________________________________

27. yes no Have you had orthodontics?

28. yes no Have you ever been treated for ulcers?

29. yes no Have you ever been treated for depression?

30. yes no Are you under litigation for this problem?

31. yes no Have you had x-rays for this problem?

32. List all medications currently in use:____
____

33. List all other medications used within the last year:__________________________________
____

34. What do you think caused this problem and what you do you think is the problem?
____
____

35. What does this problem keep you from doing?______________________________________
____

36. Other pertinent comments that you wish to add:_____________________________________
____
____
____

To the best of my knowledge this information is correct:

____________________________ ____________________________
Patient's signature Date

Please return completed form so that we may arrange an appointment.

Please bring "Splint" if applicable