

# 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
<i>#1 = the most severe symptom</i>	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 \_\_\_\_\_

**LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING**

- |                                                                      |                                                                        |                                                                        |
|----------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics    | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone        | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills       | Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills   |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine        | Y <input type="checkbox"/> N <input type="checkbox"/> Insulin          | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs      |

Other current medications: \_\_\_\_\_

**MEDICAL HISTORY**

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

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

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY			FREQUENCY			DURATION				
		MODERATE		OCCASIONAL (MONTHLY OR LESS)	FREQUENT (WEEKLY)	CONSTANT (EVERY DAY)	MINUTES		DAYS			
		MILD	SEVERE				SECONDS	HOURS	WEEKS			
L R B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HISTORY OF SYMPTOMS**

When did your condition first occur? \_\_\_\_\_

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

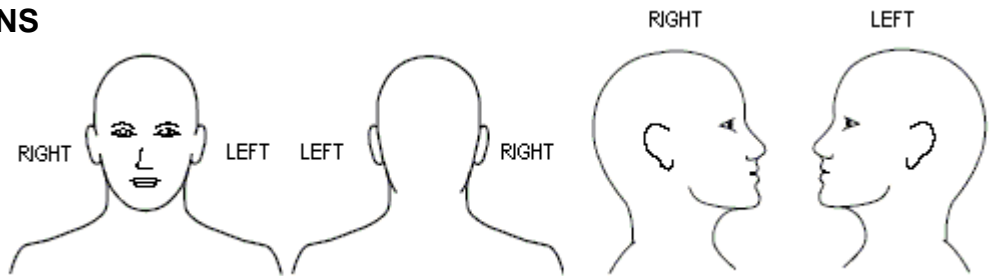
- |                                                                              |                                                                           |                                                                |                                                               |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------|
| Y <input type="checkbox"/> N <input type="checkbox"/> Motor vehicle accident | Y <input type="checkbox"/> N <input type="checkbox"/> Playground incident | Y <input type="checkbox"/> N <input type="checkbox"/> Fall     | Y <input type="checkbox"/> N <input type="checkbox"/> Injury  |
| Y <input type="checkbox"/> N <input type="checkbox"/> Motorcycle accident    | Y <input type="checkbox"/> N <input type="checkbox"/> Athletic endeavor   | Y <input type="checkbox"/> N <input type="checkbox"/> Accident | Y <input type="checkbox"/> N <input type="checkbox"/> Unknown |
| Y <input type="checkbox"/> N <input type="checkbox"/> Work related incident  | Y <input type="checkbox"/> N <input type="checkbox"/> Fight               | Y <input type="checkbox"/> N <input type="checkbox"/> Illness  |                                                               |

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     |  | B Burning   |
| MODERATE PAIN |  | D Dull      |
| SEVERE PAIN   |  | 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 \_\_\_\_\_