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Orofacial Pain and TMJ Questionnaire

This is a supplemental questionnaire for patients with Acute and Chronic Facial or Jaw Pain, Clicking and/or locking of the Jaw.

Occupation:		
Are you caregiver to dependents (young and/or old):	Yes	No
Do you find day to day life stressful? Personally / Professionally	Yes	No
Do you take medication/ supplements/ herbal remedies? If yes… Please List and include for what condition it is taken.	Yes	No
Do you wear, or have you ever worn, a splint, bite plate, or dental appliance?	Yes	No
Have you ever been treated for a "bad bite" or malocclusion?	Yes	No
Have you ever had orthodontic treatment? Wire Braces? Invisalign?	Yes	No
Do you feel that you squeeze for fit your teeth together?	Yes	No
Do you feel that you have one bite of more than one?	One	Multiple
Do you have extensive dental crowns and bridges?	Yes	No
Do you have missing back teeth?	Yes	No
Do you wear a removable partial denture?	Yes	No
Have you ever been treated for problems of your jaw joint or for facial muscle spasms?	Yes	No
Do you ever awaken with an awareness of your teeth or jaws?	Yes	No
Are you aware of clenching your teeth during the day?	Yes	No
Have you ever been told that you grind your teeth in your sleep?	Yes	No
Do your teeth hurt from biting?	Yes	No
Do you have any pain or soreness around your eyes, ears or other parts of your face?	Yes	No
Do you have occasional headaches?	Yes	No
Do you have "tension" headaches?	Yes	No
Do you ever have migraine headaches? Are they one sided or two sided?	Yes	No
Do you frequently have stiff neck muscles or neckaches?	Yes	No

Question		
Do your jaw muscles become tired frequently?	Yes	No
Do you have difficulty in opening your mouth widely?	Yes	No
Have you ever had arthritis?	Yes	No
Have you ever received a severe blow to the side of the head or jaw, whiplash, fall to the chin or face. (including childhood)	Yes	No
Does your jaw get "stuck," "locked," or "go-out"? If yes is that when you….. cannot open,…... or cannot close?	Yes	No
Have you ever had problems with your ears, such as ringing or change of hearing?	Yes	No
Do you ever hear grainy sounds from your jaw joints?	Yes	No
Do you ever hear clicking or popping sounds from your jaw joints?	Yes	No
Do you have a history of traumatic dental surgery ?	Yes	No
Do you have a history of being intubated/ general anesthesia?	Yes	No
Do you have difficulty hearing or alteration in hearing?	Yes	No
Are you presently in any pain from your jaw joints or muscles?	Yes	No
Does pain or discomfort from your jaw joint prevent your being able to work?	Yes	No
Are there times when you notice that this problem or pain is less or gone completely? Explain	Yes	No
Do you have a problem with insomnia?	Yes	No
Do you wake up feeling refreshed?	Yes	No
Do you sleep well?	Yes	No
Is your pain greater throughout the day or is it greater at night or in the morning?	AM	PM
Do you take more than one alcoholic drink per day?	Yes	No
Do you smoke cigarettes, marijuana, vape etc?	Yes	No
Do you bite your nails, tongue, lips, pens, pencils?	Yes	No
Do you spend significant periods of time driving? on computers? or on digital devices?	Yes Yes Yes	No No No
Do you feel you need treatment for this problem? If Yes..What is your expectation of treatment?	Yes	No

Please describe any other notable features of your condition that you feel can aid in the diagnosis, treatment or management of you and or your condition. If you need more space, please attach a separate form.

Please list (in order) all doctors, therapists, allied health professionals who have treated you for this condition.
Contact information is appreciated for these providers

- ____ field of specialty/ treatment ___________
  - Phone #
- ____ field of specialty/ treatment____________
  - Phone #
- ____ field of specialty/ treatment____________
  - Phone #
- ____ field of specialty/ treatment____________
  - Phone #
- ____ field of specialty/ treatment____________
  - Phone #
- ____ field of specialty/ treatment____________
  - Phone #
- ____ field of specialty/ treatment____________
  - Phone #

Have you had recent (last 2 years) CT, MRI, CBCT, panoramic radiographs, or other diagnostic tests? Please list and include which provider prescribed them?

Thank you,

With the above information preferably received at our office prior to your scheduled appointment, we will be able to begin the evaluation process. Your cooperation is appreciated and will help us in arriving at a more accurate diagnosis and more effective treatment of your condition.