TEMPOROMANDIBULAR DISORDER QUESTIONNAIRE

Patient Name ______________________________ Date ______________________________

	Question	YES	NO
1.	Do you have grating, clicking or popping sound in either or both jaws when you chew?	☐	☐
2.	Do you have sensations or stiffness, pressure or blockage, ringing, hissing or buzzing in your ears?	☐	☐
3.	Do you ever feel dizzy or faint?	☐	☐
4.	Is your jaw painful or locked when you wake up in the morning?	☐	☐
5.	Do you consider yourself chronically fatigued?	☐	☐
6.	Are you ever nauseated for no apparent reason?	☐	☐
7.	Do your fingers sometimes go numb?	☐	☐

8. Check any area where you have pain or soreness:

☐ Jaw Joints	☐ Upper jaw or teeth	☐ Back of head
☐ Forehead	☐ Lower jaw or teeth	☐ Chewing muscles
☐ Temples	☐ Side of neck	☐ Behind the eyes
☐ Tongue	☐ ______________	

	Question	YES	NO
9.	Is it hard to move your jaw side-to-side, forward or backward?	☐	☐
10.	Do you have difficulty chewing?	☐	☐
11.	Do you have back teeth missing?	☐	☐
12.	Have you had extensive dental crowns and bridgework?	☐	☐
13.	Do you clench your teeth during the day?	☐	☐
14.	Do you grind your teeth at night? (Ask someone else)	☐	☐
15.	Do you ever have a headache when you wake up?	☐	☐
16.	Have you had whiplash injury?	☐	☐
17.	Have you worn a cervical collar or had neck traction?	☐	☐
18.	Have you ever had a blow to the chin, face or head?	☐	☐
19.	Have you reached the point at which drugs no longer relieve your symptoms?	☐	☐
20.	Does chewing gum start your symptoms?	☐	☐
21.	Does your jaw deviate to the left or right when you open wide?	☐	☐
22.	When your mouth is wide open, can you insert three fingers into your mouth vertically?	☐	☐

23. Please write a brief narrative of your past medical and dental history (including injuries) pertaining to the jaw joint:

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