

TEMPOROMANDIBULAR DISORDER QUESTIONNAIRE

Patient Name _____ Date _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you have grating, clicking or popping sound in either or both jaws when you chew? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have sensations or stiffness, pressure or blockage, ringing, hissing or buzzing in your ears? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you ever feel dizzy or faint? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is your jaw painful or locked when you wake up in the morning? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you consider yourself chronically fatigued? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you ever nauseated for no apparent reason? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do your fingers sometimes go numb? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Check any area where you have pain or soreness: | | |
| <input type="checkbox"/> Jaw Joints <input type="checkbox"/> Upper jaw or teeth <input type="checkbox"/> Back of head | | |
| <input type="checkbox"/> Forehead <input type="checkbox"/> Lower jaw or teeth <input type="checkbox"/> Chewing muscles | | |
| <input type="checkbox"/> Temples <input type="checkbox"/> Side of neck <input type="checkbox"/> Behind the eyes | | |
| <input type="checkbox"/> Tongue <input type="checkbox"/> _____ | | |
| 9. Is it hard to move your jaw side-to-side, forward or backward? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have difficulty chewing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have back teeth missing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had extensive dental crowns and bridgework? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you clench your teeth during the day? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you grind your teeth at night? (Ask someone else) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you ever have a headache when you wake up? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you had whiplash injury? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you worn a cervical collar or had neck traction? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a blow to the chin, face or head? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you reached the point at which drugs no longer relieve your symptoms? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does chewing gum start your symptoms? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Does your jaw deviate to the left or right when you open wide? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. When your mouth is wide open, can you insert three fingers into your mouth vertically? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Please write a brief narrative of your past medical and dental history (including injuries) pertaining to the jaw joint: | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |