ashford
DENTAL CARE

it all starts with a smile...

TMJ HEALTH QUESTIONNAIRE

NAME_____ **DATE** _____

CHIEF CONCERN _____

DATE OF ONSET_____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N

Have you ever been involved in any serious Accidents, such as a car accident? Y N

Any whiplash neck injuries? Y N

Details_____

_____

PAIN SYMPTOMS

Do you get headaches? Y N

Do you get migraine headaches? Y N

Do you frequently have neck aches or Stiff neck muscles? Y N

Do you have earaches or pain in front Of the ears? Y N

Have you ever had chronic shoulder or back pain? Y N

Do you have trouble sleeping soundly? Y N

Are your jaws tired when you awaken? Y N

Does it hurt when you chew or open wide To take a big bite? Y N

Must you chew exclusively on one side? Y N

Are your teeth sore when your awaken? Y N

Do you get headaches in the right or left temple areas? Y N

Do you get headaches in the front or back Of your head? Y N

Does your jaw 'feel tired' after a big meal or Dental visit? Y N

Do you clench your teeth during the day? Y N

Do you clench your teeth at night? Y N

Do you grind your teeth when asleep? Y N

Does your jaw get stuck so that you can't open Freely? Y N

Have your wisdom teeth been extracted? Y N

Are you aware of an uncomfortable bite Y N

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PAIN HISTORY

Does anything make you feel better?

_____

When are your pain symptoms the worst?

_____

What medications, if any, are you taking?

_____

How often do you take medication for relief of?

_____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N

Do you feel or hear a clicking,popping or cracking' noise from either jaw joint? Y N

Are there any foods you avoid eating? Y N

Do you ever get dizzy?

Has your jaw ever locked when you were unable to open or close? Y N

Do you have difficulty opening wide or Yawning? Y N

Do you ever feel faint? Y N

Do you ever feel nauseated?

Is there a family history of jaw joint ? Y N

BREATHING AND MEDICAL

Do you suffer from arthritis or pain in Other joints? Y N

Is your nose stuffed when you do not Have a cold? Y N

Do you have allergies? Y N

Do you suffer from skin problems? Y N

Do you suffer from nervous stomach or Ulcers? Y N

Do you suffer from constipation? Colitis? Y N

Do you have sinus problems? Y N

Do you snore at night? Y N

Have you been diagnosed with Sleep Apnea? Y N

Have you had a sleep study done at a Sleep clinic (hospital)? Y N

Are you taking any medication? Y N

If yes Details_____

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