Mark A. Piper, M.D., D.M.D.

TMJ PROBLEM QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS | *DO NOT WRITE IN THIS SPACE*

I. **Name** ______________________ **Date** __________
Age __________ **Referred by** ______________

II. Which of the following do you have?
Headaches   Neck pain   Jaw pain   Ear pain
Facial pain   Other ______________
Which side hurts (circle one)   Right   Left   Both
Comments ______________________

III. Place an (X) in the circle (s) where you hurt.

RIGHT SIDE   LEFT SIDE

Place an (X) on your pain level.   (0 = no pain, 10= highest pain)

RIGHT		LEFT
0 1 2 3 4 5 6 7 8 9 10	BEST	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	AVG	0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10	WORST	0 1 2 3 4 5 6 7 8 9 10

IV. How long have you had this pain? ______________
Is this pain constant?   Y   N
Is the pain (circle all that apply)   Aching   Burning   Stabbing
Other ______________________

V. Is the pain worse in the (circle all that apply)
Morning   Afternoon   Evening   Night

VI. Have you ever injured or sustained any form of trauma or whiplash
to your (circle all that apply)   Jaw   Head   Neck
(If so, please complete separate Trauma Questionnaires for each trauma or whiplash)

VII. What makes the pain better? ______________

What makes the pain worse? ______________

What medication(s) do you take or have previously taken for your pain?

MEDICATION	DOSE	FREQUENCY

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Name: ____________________ **Date** ________

VIII. Does it hurt to chew? Y N L R
Does it hurt to open wide? Y N L R
Which side of your jaw makes a popping noise? L R
Which side of your jaw makes a clicking noise? L R
Which side of your jaw makes other noises? L R
What noises? ____________________
When did you first notice joint noises? ____________________

IX. Has your jaw ever locked? Y N L R
Did it lock open or closed? Open Closed
When did this first happen? ____________________
When did this last happen? ____________________
Has your jaw ever slipped out of place? Y N L R

X. Have you noticed a change in your bite? Y N
Did you notice a change at your front teeth? Y N
Did you notice a change at your back teeth? Y N
Has your profile changed? Y N
Have you noticed any crookedness or asymmetry in your jaw? Y N
When did you notice the asymmetry? ____________________
Other ____________________

XI. Are your teeth sore or sensitive? Y N
Do you clench your teeth? Y N
Do you grind your teeth? Y N
Do you do this during the day or night? Day Night
When did you start clenching or grinding? ____________________

XII. Do you have problems with your ears? Y N L R
Ringing? Y N L R Dizziness? Y N
Hearing? Y N L R Other ____________________

XIII. Is it difficult to swallow? Y N
Is it painful to swallow? Y N
Have you noticed lumps in your face? Y N
Throat? Y N Neck? Y N
Other ____________________

XIV. Have you had any prior treatment for your symptoms? Y N
Splint or Night Guard 1 Y N When? ________
Did it help? Y N
Splint or Night Guard 2 Y N When? ________
Did it help? Y N
Bite Adjustment? Y N When? ________
Orthodontics? Y N When? ________
Did it help? Y N
Surgery? Y N When? ________
What type and which side? ____________________

____
Did it help? Y N
Explain ____________________

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Name: **Date**

XIV. Did you **ever** have orthodontics? Y N
What were they treating?

Did you have tooth extractions? Y N
If so, which teeth?
Did you wear elastics? Y N
Did you wear any type of applianc Y N
If so, what type of applicance (i.e.headgear)?

XV. Describe your problems as you understand them:

XVI. Reports may be sent to my:
Medical Doctor
Dentist
Other

XVII. I have completed the above to the best of my knowledge and I consent to the use of my x-rays, records and photos for scientific publication or teaching providing my name remains anonymous.

Signature
(Parent or Legal Guardian must also sign if the patient is under the age of 18.)

Date

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