Print Form

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PRACTICE LIMITED TO ORTHODONTICS

SCREENING QUESTIONNAIRE FOR TMJ PROBLEMS

Date:_____

1. Name _____ Age _____ Phone ( ) _____-_____
2. Address _____
3. Referred by Dr. _____
4. Do you have headaches? ____ Neck pain? ____ Jaw pain? ____ Ear pain? ____
   Face pain? ____ Eye pain? ____ Other? ____ Which side hurts? Right ___ Left ___
   Both _____
5. How long have you had these symptoms? _____ years_____ months _____ days
6. Is the pain constant? ____ aching? ____ shooting? ____ burning? ____ stabbing? ___
   electrical? ____ other? ____ Worse in the afternoon? ____Worse in the morning? ____
7. Does it hurt to chew? _____ Open wide? _____
8. Does your jaw make a popping noise? ____ clicking? ____ grinding? ____ other? ___
9. Has your jaw ever "locked" or slipped out of place? _____
10. Do you ever clench or grind your teeth? _____ During the day? ____ At night? ____
11. Do you have problems with your ears? ____ hearing? ___ dizziness? ___ other? ____
12. Is it difficult to swallow? _____ painful? _____
13. Are your teeth sore or sensitive? ____
14. Are you taking medicine of any kind?_____
15. Have you been treated for this problem by another Doctor? _____
    If so, Name: _____
    Address: _____
    Treatment: _____
16. Describe your problem in your own words