TMJ Patient Questionnaire

Patient Name:_____

Date:_____

Answer all that apply.

YES	NO	
		1) Do you have frequent or regular headaches?
		Upon awakening
		Late afternoon
		2) Are your jaw muscles sore or tender?
		3) Are your joints sore or tender when you eat or chew?
		4) Have you ever received an injury to your jaw or face?
		If yes: Describe:
		5) Do your joints make any noise such as snapping, clicking, or popping?
		6) Do your joints lock when you are trying to open or close?
		7) Do you have any teeth that are sensitive, sore, aching, or uncomfortable?
		8) Have you ever worn a splint or nightguard?
		If yes: How many?_____
		9) Are you taking or have you taken any medication for these symptoms?
		If yes: Describe:
		10) Have you ever seen a dentist or a TMJ specialist for treatment of any of the above symptoms?
		If yes: How many?_____