JACOB GRAPEVINE DDS

SIGNATURE DENTISTRY

General & Cosmetic Dentistry in Plano TX

FACIAL PAIN (TMJ) QUESTIONNAIRE

Name _____ Date of Birth _____
Address _____
City/State _____ Zip _____
Contact Number _____ Email Address _____
Referred by: _____

Please describe your problem _____

_____

Is this condition the result of an accident? **Y** or **N**
If yes, date of accident _____
Please describe _____

Have you ever been injured by a blow to the jaw? **Y** or **N**
When (year)? _____

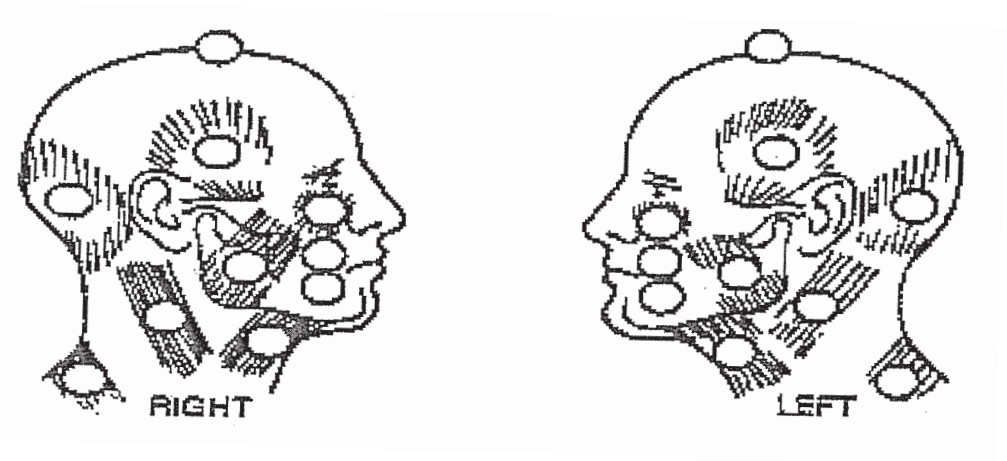
Which side hurts? _____

Is the pain constant ❑ or ❑ intermittent? _____

Is the pain worse in the morning, afternoon, or evening? _____

Does it hurt to move your? _____ or chew? _____

On the figures below, please indicate the level of pain in any area where a circle is found. If no pain leave circle blank. Represent pain level by ① = mild discomfort, ② = moderate, ③ = pain is severe enough to keep you aware of it.



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FACIAL PAIN (TMJ) QUESTIONNAIRE
(continued)

Have you ever been bothered by noises in your jaw joints?
Describe _____
Does your jaw make noises now? _____ which side? _____
Please describe: Clicking? _____ Popping? _____ Grinding? _____
When? _____ For how long? _____

Has your jaw ever locked open? _____ closed? _____
When? _____ How often? _____

Do you have any of the following problems? If so, please describe:
Headaches _____
Neckaches _____
Shoulder pain _____
Ear pain _____
Ringing in the ears _____
Dizziness _____
Change in hearing _____

Do you grind or clench your teeth? _____
At night? _____ During the day? _____

Do you have sore sensitive teeth? _____

Do you have trouble getting to sleep? _____
Do you sleep well? _____

Do you consider yourself to be under a lot of stress? _____
Are you nervous or anxious about anything? _____

Have you ever had a nervous stomach, ulcers, skin disease? _____

Do you have or have you ever had arthritis? _____

Does your pain keep you from doing anything? _____
If yes, what? _____

Do you take medications for the pain? _____
If yes, what? _____

(continued...)

FACIAL PAIN (TMJ) QUESTIONNAIRE
(continued)

Do you take medications for relaxation? _____
If yes, what? _____

Have you had any treatments for your problem? _____
If yes, what kind? _____

Check BOX and please describe results:

	Y	N	
Bite Splint	❑	❑	_____
Medication	❑	❑	_____
Physical Therapy	❑	❑	_____
Counseling	❑	❑	_____
Orthodontics	❑	❑	_____
Surgery	❑	❑	_____
Other	❑	❑	_____