TEMPOROMANDIBULAR JOINT QUESTIONNAIRE

NAME________________________________ AGE_____ SEX_____ DATE__________

DIRECTIONS: Please circle the correct answer.

1. Do you have clicking, popping, or grating noise in your:
   right jaw joint?.............................. YES NO
   left jaw joint?............................... YES NO
   If you have no jaw joint sounds, skip to question four (4).

2. When did you first notice the noise?______________________________

3. Has the noise recently become more pronounced?.......... YES NO
   When?____

4. Do you have pain in or around the right joint?.......... YES NO
   the left joint?........... YES NO
   If you have no jaw joint pain, skip to question ten (10).

5. When did you first notice the pain?_______________________________

6. Has the pain recently become more pronounced?........... YES NO
   When?____

7. Is the pain worse: Mornings__________ At meals______________
   Evenings__________ No specific time_______

8. Is the pain: Dull______________ Continuous_____________
   Stabbing__________ Intermittent___________
   Throbbing_________ Other__________________

9. Does the pain sometimes feel like it is in your ear?.... YES NO

10. Do you think this problem has affected your hearing?.... YES NO

11. Do you have frequent headaches?......................... YES NO
    If yes, how frequent?____
    Any particular time more than others?_____________________________
    Please describe headaches:____

12. Does your jaw problem interfere with your normal activites? YES NO

13. Are you taking or have you taken medication for this problem? YES NO
    Explain:____
    ____

14. Did anything occur which might be related to the onset of this problem?.. YES NO
    Explain:____
    ____

15. Do you have difficulty chewing?........................ YES NO
Because of:
Pain in joint_____________ Limited opening__________
Pain in teeth_____________ Missing teeth____________
Clicking__________________ Other____________________

16. Has your mouth ever locked open so yo were unable to close it?
YES NO
Explain:____
____
____

17. Have you had problems opening your mouth wide?......... YES NO
Explain:____
____
____

18. Please indicate the time sequence in which you became aware of the following problems (1st, 2nd, 3rd, etc.).
(Number only those problems which apply to you.)

Pain_____ Noise_____ Limited Opening____ Locking_____ Other_____

19. Which aspects of your problems concern you the most?
____
____
____

20. Are you aware of clenching your teeth?................ YES NO

21. Do you grind your teeth?.............................. YES NO
When?____

22. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in the immediate family or other stressful events?........... YES NO

23. Do you think nervous tension seems to affect this problem? YES NO
Explain:____
____

24. Have you had problems with other joints?.............. YES NO

25. Have you had orthodontic treatment?.................... YES NO
When?_____________________________ Where?_______________________

26. Have you had recent dental treatment?.................. YES NO
Explain:____
____

27. Have you had x-rays taken for this problem?............ YES NO
When?_____________________________ Where?_______________________

28. Have you received previous treament for this problem?.. YES NO
When?_____________________________ Where?_______________________