TEMPOROMANDIBULAR JOINT QUESTIONNAIRE

Name _____**Birthdate** _____ **Age** _____ **Date** _____

Directions: *If you can answer YES to the question asked, put a circle around the YES.*
If you can answer NO to the question asked, put a circle around the NO.

Please answer all questions

1. Do you have clicking, popping or grating noise in your right jaw joint ……Yes……No
2. In your left jaw joint? ……..Yes …..No
3. When did you first notice the noise? _____
4. Has the noise recently become more pronounced? ……Yes ….No
5. When? _____
6. Has the pain recently become more pronounced? …… Yes…...No
7. When? _____
8. Is the pain worse: Mornings_____ At Meals _____
   Evenings _____ No specific time _____
9. Is the pain: Dull _____ Continuous _____
   Stabbing _____ Intermittent _____
   Throbbing _____ Other _____
10. Does the pain sometimes feel like it is in your ear? ……Yes ….No
11. Do you think this problem has affected your hearing? ……Yes ….No
12. Does your jaw problem interfere with your normal activities? ……Yes….No
13. Are you taking or have you taken medication for this problem? ……. …Yes….No
14. Did anything occur which might be related to the onset of this problem? ……Yes…No

    Please explain: _____

_____

_____

15. Do you have any difficulty chewing? ……Yes…No
16. Because of: Pain in joint_____ Limited opening _____
    Pain in teeth _____ Missing teeth _____
    Clicking _____ Other _____

17. Has your mouth ever locked open so you were unable to close it? ……Yes…No

Explain: _____
_____
_____

18. Have you had problems opening your mouth wide? ……Yes…No

Explain: _____
_____
_____

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

Pain_____ Noise _____ Limited opening _____ Locking _____

Other _____

20. Which aspects of your problems concern you the most?_____
_____
_____

21. Are you aware of clenching your teeth? ……Yes…No

22. Do you grind your teeth? ……Yes…No
When? _____

23. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, Change of employment, death in immediate family or other stressful events? …….Yes…No

24 Do you think nervous tension seems to affect this problem? ……Yes...No
Explain: _____

25. Have you had problems with other joints? ……Yes..No

26. Have you had orthodontic treatment? ……Yes..No
When _____ Where _____

27 Have you had recent dental treatment? ……..Yes..No

28. Have you had X-rays taken for this problem? ……Yes..No
When _____ Where _____

29. Have you had previous treatment for this problem? ……Yes..No