TMJ QUESTIONNAIRE

Form 401E

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible Please sign each page.

PATIENT INFORMATION

TODAY'S DATE: _____

☐ MR. ☐ MS. ☐ MISS ☐ MRS. ☐ DR. NAME: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL _____

RESPONSIBLE PARTY _____

PHYSICIAN NAME & ADDRESS _____

_____ REFERRED BY: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most severe symptom, #2 the next, etc.

2. Then rate your complaints for frequency and intensity:

Frequency:
(1- SELDOM, 2-OCCASIONAL, 3- FREQUENT, 4- EVERY DAY)

Intensity:
(0 is NO PAIN and 10 is MOST SEVERE PAIN)

Number		Frequency	Intensity
#1 = the most severe symptom		1-4	0-10
____	Back Pain	____	____
____	Dizziness	____	____
____	Ear Congestion	____	____
____	Ear Pain	____	____
____	Eye Pain	____	____
____	Facial Pain	____	____
____	Fatigue	____	____
____	Headaches	____	____
____	Jaw Clicking	____	____
____	Jaw Joint Noises	____	____
____	Jaw Locking	____	____
____	Jaw Pain	____	____
____	Limited Mouth Opening	____	____
____	Muscle Soreness	____	____
____	Muscle Twitching	____	____
____	Neck Pain	____	____
____	Pain when Chewing	____	____
____	Ringing in the Ears	____	____
____	Shoulder Pain	____	____
____	Sinus Congestion	____	____
____	Throat Pain	____	____
____	Visual Disturbances	____	____
Other - write in:	____ _____	____	____

LIST ANY MEDICATIONS WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y☐ N☐ Antibiotics
Y☐ N☐ Aspirin
Y☐ N☐ Codeine
Y☐ N☐ Iodine
Y☐ N☐ Latex
Y☐ N☐ Local anesthetics
Y☐ N☐ Metals
Y☐ N☐ Penicillin
Y☐ N☐ Plastic
Y☐ N☐ Sedatives
Y☐ N☐ Sleeping pills
Y☐ N☐ Sulfa drugs

Other allergens:
_____
_____
_____
_____

Patient Signature _____ Date _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Y ☐ N ☐ Antibiotics
Y ☐ N ☐ Anticoagulants
Y ☐ N ☐ Blood thinners
Y ☐ N ☐ Codeine
Y ☐ N ☐ Cortisone
Y ☐ N ☐ Diet pills
Y ☐ N ☐ Heart medication
Y ☐ N ☐ Insulin
Y ☐ N ☐ Muscle relaxants
Y ☐ N ☐ Pain medication
Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Sulfa drugs

Other current medications: _____

MEDICAL HISTORY

Y ☐ N ☐ Anemia
Y ☐ N ☐ Arteriosclerosis
Y ☐ N ☐ Asthma
Y ☐ N ☐ Autoimmune disorders
Y ☐ N ☐ Bleeding easily
Y ☐ N ☐ Blood pressure ____ ☐ High ☐ Low
Y ☐ N ☐ Cancer
Y ☐ N ☐ Chemotherapy
Y ☐ N ☐ Chronic fatigue
Y ☐ N ☐ Current pregnancy
Y ☐ N ☐ Diabetes
Y ☐ N ☐ Difficulty concentrating
Y ☐ N ☐ Dizziness
Y ☐ N ☐ Emphysema
Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Fibromyalgia
Y ☐ N ☐ Frequent snoring
Y ☐ N ☐ Hay fever
Y ☐ N ☐ Hearing impairment
Y ☐ N ☐ Heart murmur
Y ☐ N ☐ Heart disorder
Y ☐ N ☐ Heart pacemaker
Y ☐ N ☐ Heart valve replacement
Y ☐ N ☐ Hemophilia
Y ☐ N ☐ Hepatitis
Y ☐ N ☐ Immune system disorder
Y ☐ N ☐ Injury to ☐ Face ☐ Neck ☐ Teeth ☐ Head ☐ Mouth
Y ☐ N ☐ Insomnia
Y ☐ N ☐ Intestinal disorders
Y ☐ N ☐ Jaw joint surgery
Y ☐ N ☐ Meniere's disease
Y ☐ N ☐ Migraines
Y ☐ N ☐ Multiple sclerosis
Y ☐ N ☐ Muscle spasms or cramps
Y ☐ N ☐ Needing extra pillows to help breathing at night
Y ☐ N ☐ Osteoarthritis
Y ☐ N ☐ Osteoporosis
Y ☐ N ☐ Poor circulation
Y ☐ N ☐ Prior orthodontic treatment
Y ☐ N ☐ Radiation treatment
Y ☐ N ☐ Rheumatic fever
Y ☐ N ☐ Rheumatoid arthritis
Y ☐ N ☐ Scarlet fever
Y ☐ N ☐ Shortness of breath
Y ☐ N ☐ Sinus problems
Y ☐ N ☐ Sleep Apnea
Y ☐ N ☐ Speech difficulties
Y ☐ N ☐ Swollen, stiff or painful joints
Y ☐ N ☐ Teeth clenching or grinding
Y ☐ N ☐ Wisdom teeth extraction

Other medical history:
_____
_____

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY: MILD	SEVERITY: MODERATE	SEVERITY: SEVERE	FREQUENCY: OCCASIONAL (MONTHLY OR LESS)	FREQUENCY: FREQUENT (WEEKLY)	FREQUENCY: CONSTANT (EVERY DAY)	DURATION: SECONDS	DURATION: MINUTES	DURATION: HOURS	DURATION: DAYS	DURATION: WEEKS
L R B	Front of your head (Frontal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Entire head (Generalized)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Top of your head (Parietal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	Back of your head (Occipital)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
L R B	In your temples (Temporal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HISTORY OF SYMPTOMS

When did your condition first occur? _____

What do you believe to be the cause of your pain or condition? _____

Y ☐ N ☐ Motor vehicle accident
Y ☐ N ☐ Motorcycle accident
Y ☐ N ☐ Work related incident
Y ☐ N ☐ Playground incident
Y ☐ N ☐ Athletic endeavor
Y ☐ N ☐ Fight
Y ☐ N ☐ Fall
Y ☐ N ☐ Accident
Y ☐ N ☐ Illness
Y ☐ N ☐ Injury
Y ☐ N ☐ Unknown

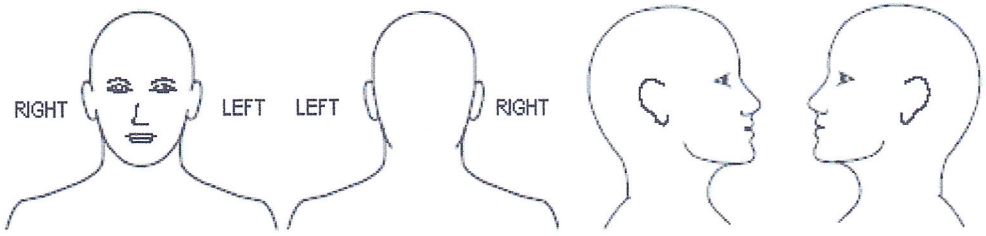
If accident, what was the date? _____

What other information is important to your pain or condition? _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

MILD PAIN ||||||
MODERATE PAIN ^^^^
SEVERE PAIN ////////

B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating



I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.

Patient Signature _____ Date _____