JANE M. Birriel, DDS
BEYOND EXPECTATIONS

TEMPOROMANDIBULAR JOINT QUESTIONNAIRE

Name:_____ Age_____ Date_____

1. Do you have clicking, popping or grating noise in your RIGHT jaw joint.....yes no
LEFT jaw joint.....yes no

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 jaw joint.....yes no
LEFT jaw joint.....yes no

5. When did you notice the pain?.....yes no

6. Has the pain recently become more pronounced?.....yes no
When?_____

7. Is the pain worse: Mornings_____ Evenings_____ At meals_____ No specific time_____

8. Is the pain: Dull_____ Stabbing_____ Throbbing_____ Continuous_____ Intermittent_____

9. Does the pain sometimes feel like it is in your ear?.....yes no

10. Do you think this problem has effected your hearing?.....yes no

11. Does your jaw problem interfere with your normal activities?.....yes no

12. Are you taking or have you taken medication for this problem?.....yes no
Explain_____

13. Did anything occur which might be related to this problem?.....yes no
Explain _____

14. Do you have frequent headaches or neckaches?.....yes no
What area?_____
How frequent?_____

15. Have you ever had a severe blow or trauma to the head, neck, or jaw?.....yes no
Which area?_____ When?_____
Explain_____

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16. What makes the pain worse?_____
What makes the pain better?_____

17. Do you have difficulty chewing?.....yes no

18. Has your mouth ever locked open so you were unable to close it?.....yes no
Explain_____

19. Have you had problems opening your mouth wide?.....yes no
Explain_____

20. Please indicate the time sequence in which you became aware of the following problems (1st, 2nd, 3rd, etc) Number ONLY those that apply to you.
PAIN_____ NOISE_____ LIMITED OPENING_____ LOCKING_____ OTHER_____

21. Which aspects of your problem concern you the most? What is your chief complaint?
_____

22. Are you aware of clenching of your teeth?.....yes no

23. Do you grind your teeth?.....yes no
When?_____

24. 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 event?.....yes no
Explain_____

25. Do you think nervous tension seems to affect this problem?.....yes no
Explain_____

26. Have you had this problems with other joints?.....yes no
Explain_____

27. Have you had orthodontic treatment?.....yes no
When?_____ Where?_____

28. Have you had recent dental care?.....yes no
When?_____ Where?_____
Explain_____

29. Have you had x-rays taken for this problem?.....yes no
When?_____ Where?_____
Explain_____

30. Have you had previous treatment for this problem.....yes no
Explain_____