

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
<i>#1 = the most severe symptom</i>	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 <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone | Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills | Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Insulin | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs |

Other current medications: _____

MEDICAL HISTORY

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

SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

L= Left R=Right B=Both sides

HEAD PAIN	LOCATION	SEVERITY			FREQUENCY			DURATION		
		MODERATE		OCCASIONAL (MONTHLY OR LESS)	CONSTANT (EVERY DAY)	MINUTES		DAYS		
		MILD	SEVERE			SECONDS	HOURS	WEEKS		
L R B	Front of your head (Frontal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Entire head (Generalized)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Top of your head (Parietal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	Back of your head (Occipital)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L R B	In your temples (Temporal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HISTORY OF SYMPTOMS

When did your condition first occur? _____

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




- | | | | |
|--|---|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Motor vehicle accident | Y <input type="checkbox"/> N <input type="checkbox"/> Playground incident | Y <input type="checkbox"/> N <input type="checkbox"/> Fall | Y <input type="checkbox"/> N <input type="checkbox"/> Injury |
| Y <input type="checkbox"/> N <input type="checkbox"/> Motorcycle accident | Y <input type="checkbox"/> N <input type="checkbox"/> Athletic endeavor | Y <input type="checkbox"/> N <input type="checkbox"/> Accident | Y <input type="checkbox"/> N <input type="checkbox"/> Unknown |
| Y <input type="checkbox"/> N <input type="checkbox"/> Work related incident | Y <input type="checkbox"/> N <input type="checkbox"/> Fight | Y <input type="checkbox"/> N <input type="checkbox"/> Illness | |

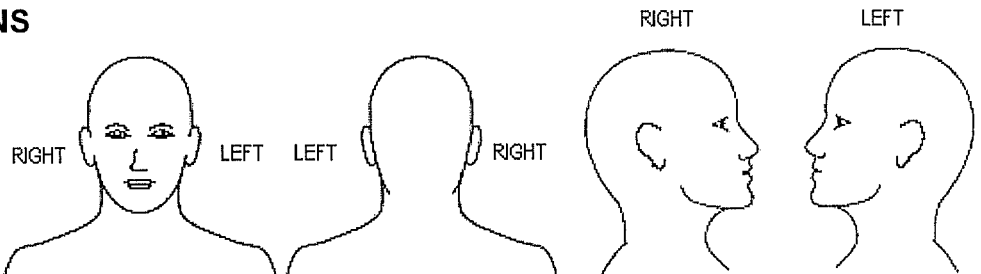
If accident, what was the date? _____

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 _____