



Dr. Hugh's Dental P.C.
(603) 444-4141

Temporomandibular Disorders (TMD) Questionnaire

CHIEF COMPLAINT(S)

Describe what you think the problem is:

What do you think caused this problem?

Describe, in order (first to last), what you expect from the treatment:

DENTAL HISTORY

How would you describe your dental health?

Poor Average Excellent Dentist Name: _____ Date of last appointment: _____

Have you had any major dental treatment in the last two years?

Yes No

If yes, please mark procedure(s):

Orthodontics Periodontics

Oral Surgery Restorative

Dates of Third Molar (wisdom tooth) extraction: _____

HISTORY OF INJURY AND TRAUMA

Is there any childhood history of falls, accidents, or injury to the face or head? Yes No

If yes, please describe:

HISTORY OF INJURY AND TRAUMA *cont*

Is there any recent history of trauma to the head or face? (Auto accident, sports injury, facial impact) Yes No If yes, please describe:

Is there any activity which holds the head or jaw in an imbalanced position? (Phone, swimming, instrument) Yes No If yes, please describe:

FACIAL PAIN PAST TREATMENT

Have you ever been examined for a TMJ problem before? Yes No If yes, by whom and when? _____

What was the nature of the problem? (Pain, noise, limitation of movement):

What was the duration of the problem?

Months? Years? _____

Is the problem getting better, worse or staying the same?

Is this a new problem?

Yes No

Have you ever had physical therapy for TMJ? Yes No If yes, by whom and when?

Have you ever received treatment for jaw problems? Yes No If yes, by whom and when?

What was the treatment? Bite Splint Medication Physical Therapy Massage

Occlusal Adjustment Orthodontics Counseling Surgery Chiropractic Other

If other, please describe:

Have you ever had injections for your TMJ with muscle relaxants (Botox, Flexeril) cortisone or anti-inflammatories? Yes No

If yes, were they effective? Yes No

How many dental appliances have you worn? ____ Were these appliances effective? Yes No

Is there any additional information that can help us in this area?

CURRENT STRESS FACTORS

PLEASE MARK EACH FACTOR THAT APPLIES TO YOU

- Death of a Spouse Business Adjustment Financial Problems Fired from Work
Death of a Family Member Major Illness or Injury Divorce Pregnancy
Marital Reconciliation New Person Joins Family Major Health Change in Family
Pending Marriage Career Change Debt Marital Separation Other

If other, please specify:

CURRENT AND PREVIOUS HABITS

PLEASE MARK YOUR ANSWER TO EACH QUESTION

- Do you clench your teeth together under stress? Yes No Don't Know
Do you grind/clench your teeth at night? Yes No Don't Know
Do you sleep with an unusual head position? Yes No Don't Know
Are you aware of any habits or activities that may aggravate this condition? Yes No
Don't Know

Please describe:

CURRENT SYMPTOMS

Please mark each symptom that applies.

HEAD PAIN, HEADACHES, FACIAL PAIN

- Forehead Temples Migraine Type Headaches Cluster Headaches Maxillary Sinus
Headaches (under the eyes) Occipital Headaches (back of the head
Hair and/or Scalp Painful to Touch with or without shooting pain)
If forehead: Left Right If temples: Left Right

THROAT PROBLEMS

- Swallowing Difficulties Tightness of Throat Sore Throat Voice Fluctuations

EYE PAIN / EAR ORBITAL PROBLEMS

- Eye Pain - Above, Below or Behind Bloodshot Eyes Blurring of Vision
Bulging Appearance Pressure Behind the Eyes Light Sensitivity Watering of the Eyes
Drooping of the Eyelids

CURRENT SYMPTOMS *cont.*

MOUTH, FACE, CHEEK & CHIN PROBLEMS

Discomfort Limited Opening Inability to Open Smoothly

TEETH & GUM PROBLEMS

Looseness and/or Soreness of Back Teeth Tooth Pain Clenching/Grinding at Night

JAW & JAW JOINT (TMD) PROBLEMS

Clicking, Popping Jaw Grating Sounds Jaw Locking Opened or Closed
 Pain in Cheek Muscles Uncontrollable Jaw/Tongue Movements

PAIN, EAR PROBLEMS, POSTURAL IMBALANCES

Hissing, Buzzing, or Ringing Sounds Ear Pain without Infection
 Clogged, Stuffy, Itchy Ears Balance Problems – “Vertigo” Diminished Hearing

NECK & SHOULDER PAIN

Arm and Finger Tingling, Numbness, Pain Reduced Mobility and Range of Motion
 Stiffness Neck Pain Tired, Sore Neck Muscle Back Pain, Upper and Lower
 Shoulder Aches

Other Pain? Please describe:

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED

Degree of current TMD pain: Mild Moderate Severe

Frequency of TMD pain: Daily Weekly Monthly Semi-Annually After Eating

Is the pain constant, continuous, or intermittent? How long does it last? Please describe:

What is the quality of the pain? Sharp, dull, burning, aching, electrical, etc. Please describe:

What makes it worse? What makes it better? Please describe:

Does the pain occur on it's own or do you need to trigger it with function, touching, etc?. Please describe:

CURRENT MEDICATIONS / APPLIANCES / TREATMENTS BEING USED *cont.*

If you were to place a Q-tip in your left ear and push forward, does that trigger pain? Please describe:

Can the pain be triggered by touching the skin with a light brush stroke with a Q-tip or pressing on an area with a Q-tip? Please describe:

Are you taking medication for the TMD problems? Yes No

If yes; what is the name of the medication, who is the prescriber, and how long have you been taking it?

Are the medications that you take effective? Yes No

If yes, under what conditions?

Are you aware of anything that makes your pain worse? Yes No

If yes, under what conditions?

Does your jaw make noise? Yes No

If yes, when and how?

Right: Clicking/Popping Grinding Other_____

Left: Clicking/Popping Grinding Other_____

Does your jaw lock open? Yes No

If yes, when did this first occur? How often does it happen now?

Has your jaw ever locked closed or partly closed? Yes No

If yes, when did this first occur? How often does it happen now?

Have any dental appliances been prescribed? Yes No

If yes, when was it made and by whom? What kind is it and when do you wear it?
