# 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 the Questions.**

1. Do you have clicking, popping or grating noise in your right jaw joint? Yes No
   In your left jaw joint? Yes No
2. When did you first notice the noise?_____
3. Has the noise recently become more pronounced? Yes No
4. Do you have pain in or around the right joint? Yes No
5. Do you have pain in or around the left joint? Yes No
6. When did you first notice the pain?_____
7. Has the pain recently become more pronounced? Yes No
   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
    Because of: Pain in Joint_____ Limited Opening_____
    Pain in Teeth_____ Missing Teeth_____
    Clicking_____ Other_____
16. Has your mouth ever locked open so you were unable to close it? Yes No
    Explain:_____
17. Have you had problems opening your mouth wide? Yes No
    Explain:_____
18. Please indicate the time sequence in which you became aware of the following:
    (1st, 2nd, 3rd, etc.) Number only those problems which apply to you:
    Pain_____ Noise_____ Limited Opening_____ Locking_____
19. Which aspects of your problems concern you the most?_____
    _____
20. Are you aware of clenching your teeth? Yes No
21. Do you grind your teeth? Yes No
22. 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
23. Do you think nervous tension seems to affect this problem? Yes No
24. Have you had problems with other joints? Yes No
25. Have you had orthodontic treatment prior to this appointment? Yes No
26. Have you had recent dental treatment? Yes No
27. Have you had x-rays taken for this problem? Yes No
    When_____ Where_____
28. Have you had previous treatment for this problem? Yes No