

# TMJ QUESTIONNAIRE

Form 401E

This questionnaire was designed to provide important facts regarding the history of your pain or condition. To assist in reaching a diagnosis and determining the source of your problem, please take your time and answer each question as completely and honestly as possible. Please sign each page.

## PATIENT INFORMATION

MR.  MS.  MISS NAME: \_\_\_\_\_  
 MRS.  DR. FIRST MIDDLE INITIAL LAST  
AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  Male  Female  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP \_\_\_\_\_  
HOW LONG AT CURRENT ADDRESS? \_\_\_\_\_ (IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS)  
PREVIOUS ADDRESS \_\_\_\_\_  
EMPLOYED BY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_  
SS#: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_  
RESPONSIBLE PARTY: \_\_\_\_\_  
FAMILY PHYSICIAN: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

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

Please mark your chief complaints and number with #1 being most important.

- |                      |                             |                           |
|----------------------|-----------------------------|---------------------------|
| Back Pain _____      | Jaw Clicking _____          | Neck Pain _____           |
| Dizziness _____      | Jaw Joint Noises _____      | Pain when Chewing _____   |
| Ear Congestion _____ | Jaw Locking _____           | Ringing in the Ears _____ |
| Ear Pain _____       | Jaw Pain _____              | Shoulder Pain _____       |
| Eye Pain _____       | Limited Mouth Opening _____ | Sinus Congestion _____    |
| Facial Pain _____    | Muscle Soreness _____       | Throat Pain _____         |
| Fatigue _____        | Muscle Twitching _____      | Tinnitus _____            |
| Headaches _____      |                             | Visual Disturbances _____ |

Other: \_\_\_\_\_  
\_\_\_\_\_

## LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION.

- |   |   |  |
|---|---|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics           | Y <input type="checkbox"/> N <input type="checkbox"/> Latex             | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic        |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin               | Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics | Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives      |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine               | Y <input type="checkbox"/> N <input type="checkbox"/> Metals            | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Iodine                | Y <input type="checkbox"/> N <input type="checkbox"/> Penicillin        | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs    |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other Allergens _____ |   |  |

## LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

- |  |  |  |
|--|--|--|
| 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"/> Sedatives        |
| 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      |
| <input type="checkbox"/> Other: _____                                |  |  |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL HISTORY

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

### SYMPTOMS: PLEASE INDICATE LOCATION AND TYPE OF ANY HEAD PAIN

KEY: L= Left R=Right B=Both sides

	SEVERITY			FREQUENCY			DURATION					
	MILD	MODERATE	SEVERE	OCCASIONAL	FREQUENT	CONSTANT	SECONDS	MINUTES	HOURS	DAYS	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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### HISTORY OF SYMPTOMS

When did your condition first occur? \_\_\_\_\_

What do you believe is the cause of your pain or condition? \_\_\_\_\_

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

If accident, date \_\_\_\_\_

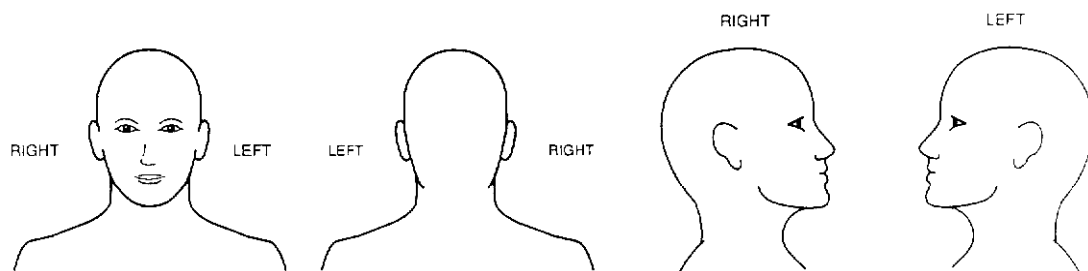
Other \_\_\_\_\_

What other information is important to your pain or condition? \_\_\_\_\_

### DRAW YOUR PAIN PATTERNS

FOLLOWING THIS KEY:

- |               |  |             |
|---------------|--|-------------|
| MILD PAIN     |  | B Burning   |
|               |  | D Dull      |
|               |  | N Numbing   |
| MODERATE PAIN |  | P Pressure  |
|               |  | S Sharp     |
| SEVERE PAIN   |  | T Tingling  |
|               |  | R Radiating |



I authorize the release of a full report of examination findings, diagnosis, treatment program, 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.

SIGNED \_\_\_\_\_ DATE: \_\_\_\_\_