Orofacial Pain & TMJ
Screening Questionnaire

Name Date Age

In your own words, please explain why you are here:

Date problem began: _____ Age problem began: _____

Previous facial injury? Yes___ No___ If so, when was the injury? _____

Please give details of the injury:

Please check if you had any of the following:

				Results:		
				Good	Fair	Poor
☐	Orthodontics	When?	_____			
☐	Occlusal adjustment	When?	_____			
☐	Physical therapy	When?	_____			
☐	TMJ splint	When?	_____			
☐	TMJ arthroscopic surgery	When?	_____			
☐	TMJ open joint surgery	When?	_____			
☐	TMJ closed joint surgery	When?	_____			

Medications taken in the past for TMJ: _____

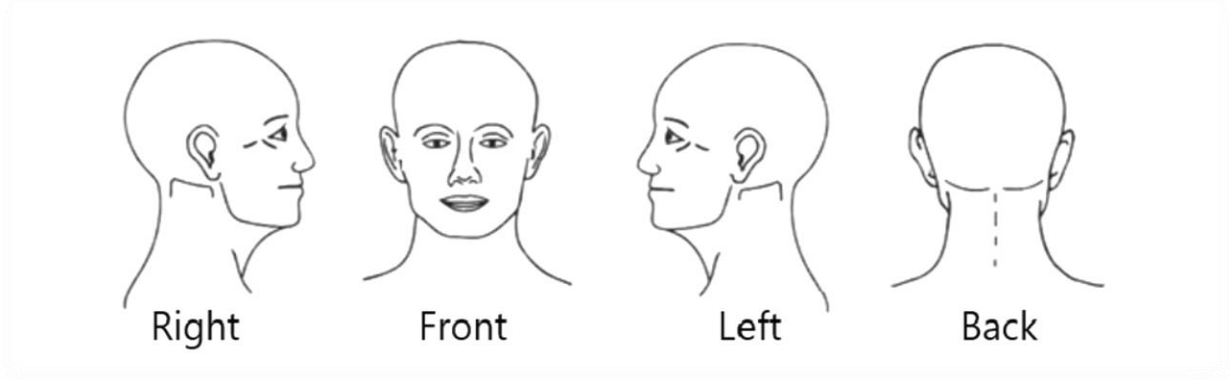
Current medications for TMJ: _____

Indicate on the following scale how severe your pain is the majority of the time

←----------→

0 No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Please indicate where you are having pain on the diagram below



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Is the pain constant or intermittent? (circle one)

Does it hurt to move your jaw? Yes ____ No____

Does it hurt to chew? Yes____ No____

Does the pain/problem limit your function? Yes____ No____

If so, how?_____

When is the pain worse? (circle one) Morning Afternoon Evening

Other time: _____

Does anything you do make the pain worse?

_____

Does anything you do make the pain better?

_____

What other doctors or health care associates have you seen regarding this pain/problem?

Does your jaw ever lock open? _____ closed? _____

How has this been treated? _____

Can you do anything to prevent or treat this? _____

Do you grind or grit your teeth? Yes____ No____

Do you have or have you had any of the following? (circle all that apply)

Sinus Problems Hearing Changes Stressful Job Sensitive Teeth Ringing in Ears

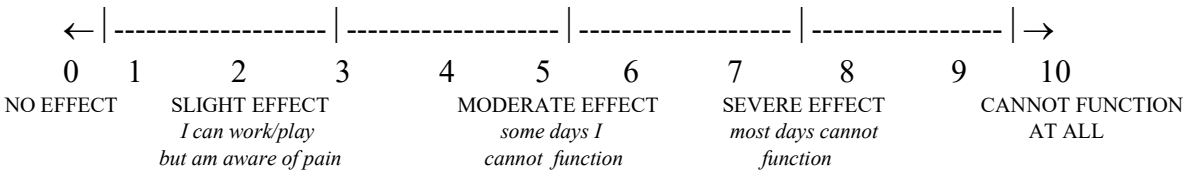
Marital Problems Periodontal Disease Dizziness Trouble Sleeping Headaches

Shoulder Pain Ulcers Migraines Arthritis Nervous Stomach Neck Ache Allergies

Skin Disease Earache Depression - to what? _____

List other medical problems: _____

The pain is having this effect on my life



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