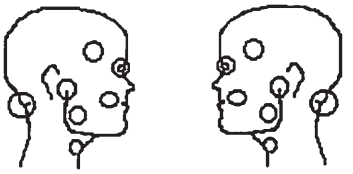
Robert Chuong, M.D., D.M.D.
*Tampa Bay Maxillofacial Surgery*

# *TMJ PROBLEM QUESTIONNAIRE*

PLEASE ANSWER ALL QUESTIONS | DO NOT WRITE IN THIS SPACE

1. NAME:_____AGE____. DATE:_____
   REFERRED BY:_____

2. DO YOU HAVE HEADACHES ?_____
   NECK PAIN ?_____ JAW PAIN ?_____
   EAR PAIN ?_____ FACIAL PAIN ?_____
   OTHER ?_____



RIGHT SIDE LEFT SIDE

*Place an (X) on the diagrams to indicate location of pain.*

WHICH SIDE HURTS?
A. *JAW PAIN*: RIGHT_____ LEFT_____ BOTH_____
*Rate the average jaw pain (from 1 to 10): RIGHT_____, LEFT_____*
B. HEADACHE: RIGHT _____, LEFT _____, BOTH _____
*Rate the average headache (from 1 to 10): RIGHT____, LEFT _____*

3. HOW LONG HAVE YOU HAD THIS PAIN?_____
   IS THE PAIN CONSTANT?_____

   WOULD YOU DESCRIBE THE PAIN AS:
   ACHING ?____ BURNING ?_____STABBING ?_____
   OTHER ?_____

4. IS THE PAIN WORSE IN THE:
   MORNING ?_____ AFTERNOON ?_____AWAKE ?_____
   WHILE SLEEPING ?_____

5. HAVE YOU EVER INJURED OR SUSTAINED ANY FORM OF TRAUMA OR WHIPLASH TO YOUR:
   JAW ?_____ HEAD ? _____ NECK ?_____
   (IF SO, PLEASE COMPLETE THE TRAUMA QUESTIONNAIRE)

6. WHAT MAKES THE PAIN WORSE ?_____
7. WHAT MAKES THE PAIN BETTER? _____
8. WHAT MEDICATIONS DO YOU TAKE OR HAVE YOU PREVIOUSLY TAKEN FOR YOUR PAIN ?

| MEDICATION | DOSE | FREQUENCY |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*TMJ PROBLEM QUESTIONNAIRE, PAGE 2*, NAME: _____ **DO NOT WRITE IN THIS SPACE**
DATE: _____

9. DOES IT HURT TO CHEW?_____OPEN WIDE?_____

10. WHICH SIDE OF JAW MAKES A POPPING NOISE?_____
CLICKING ? ____GRINDING ?_____
OTHER NOISE?_____
WHEN DID YOU FIRST NOTICE JAW JOINT SOUNDS?_____

11. HAS YOUR JAW EVER LOCKED ? _____
OPEN POSITION ? _____CLOSED POSITION?_____
WHEN DID THIS FIRST HAPPEN?_____
LAST HAPPEN ? _____

12. HAVE YOU NOTICED A CHANGE IN YOUR BITE ? _____
FRONT TEETH?_____BACK TEETH ?_____
13. HAS YOUR PROFILE CHANGED?_____
14. HAVE YOU NOTICED ANY CROOKEDNESS OR ASYMMETRY
OF YOUR FACE OR JAW?_____WHEN?_____

13. DO YOU HAVE PROBLEMS WITH YOUR EARS?_____
IF SO RIGHT LEFT OR BOTH
DIZZINESS?_____ RINGING?_____
HEARING? _____ PAIN ? _____

14. DO YOU NOTICE FACIAL NUMBNESS ?_____
IF SO WHERE? _____

15. DO YOU NOTICE FACIAL SWELLING ? _____
IF SO WHERE? _____

16. HAVE YOU NOTICED ANY LUMPS IN YOUR:
FACE ? _____THROAT ? _____ NECK ?_____
OTHER ?_____

17. HAVE YOU HAD ANY PRIOR TREATMENT FOR THIS?
A) SPLINT?_____WHEN? _____DID IT HELP?_____
B) NIGHTGUARD ? _____ WHEN? _____ DID IT HELP?____
C) BITE ADJUSTMENT? _____WHEN? _____ DID IT HELP ?____
D) ORTHODONTICS?_____WHEN? _____ DID IT HELP?____
E) PHYSICAL OR CHIROPRACTIC THERAPY?
____ WHEN?_____DID IT HELP?_____
F) INJECTIONS? _____WHEN? _____ DID IT HELP? ____
G) SURGERY? _____ __WHEN ? _____DID IT HELP?____
H) OTHER? _____

18. DESCRIBE THE PROBLEMS IN YOUR OWN WORDS:
_____
_____
_____
_____

Signature:_____
Date: _____