## TMJ QUESTIONNAIRE



Today's Date:	

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION	٧			WHAT ARE THE CHIE	F COMPL	aints foi
☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs.			∕Iale ☐ Female	WHICH YOU ARE SEE		
Name:			<ol> <li>Please number your complaints with #1 being the most sever symptom, #2 the next etc.</li> </ol>			
Address:				2. Then rate your complaints for fr	equency and i	ntesiy:
City/State/Zip:				F		
Employed By:				Frequency: (1 - Selcome, 2 - Occasional, 3 - Fre	eguent, 4 - Eve	rv Dav)
Address:					1 /	, ,,
SS#: Hoi				Intensity: (0 is NO PAIN and 10 is MOST SEVE	ERE PAIN	
Work Phone:	Ce <b>ll</b> Pho	ne:	_	Number	Frequency	Intesity
Email:				#1 = the most severe symptom	1-4	0-10
Responsible Party:				Back Pain		
Physician Name & Address:				Dizziness		
				Ear Congestion		
Referred By:				Ear Pain		
neierred by:				Eye Pain		
				Facial Pain		
LIST ANY MEDICATION	S WHIC	Н Н	AVE CAUSED	Fatigue		
AN ALLERGIC REACTIO	N			Headaches		<del></del>
Y N Antibiotics	Υ	N	Metals	Jaw Clicking Jaw Joint Noises		
Y N Aspirin	Υ	Ν	Penici <b>ll</b> in	Jaw Joint Noises		
Y N Codeine	Υ	N	Plastic	Jaw Locking		
Y N Iodine Y N Latex	Y Y	N N	Sedatives Sleeping pills	Limited Mouth Opening		
Y N Local anasthetics	Ϋ́		Sulfa drugs	Muscle Soreness		
	-			Muscle Twitching		<del></del>
Other allergens:		Neck Pain	·	<del></del>		
				Pain when Chewing		
				Ringing in the Ears		<del></del>
				Shoulder Pain		<del></del>
				Sinus Congestion		
				Throat Pain		
				Visual Disturbances		
				Other:		
Patient Signature:				Date:		

"If excellence is available, GOOD IS NOT ENOUGH"

## TMJ QUESTIONNAIRE



Today's Date:	

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION			WHAT ARE THE CHIEF COMPLAINTS FOR				
☐ Mr. ☐ Ms. ☐ Miss ☐ Mrs.	Dr.		Male 🔲 Female	WHICH YOU ARE SEEI	KING TRE	EATEMENT?	
Name:				1. Please number your complaints	s with #1 being	g the most severe	
Age: Da	te of Birth:			symptom, #2 the next etc.			
Address:				2. Then rate your complaints for fr	equency and i	ntesiy:	
City/State/Zip:				_			
Employed By:				Frequency: (1 - Selcome, 2 - Occasional, 3 - Fre	eauent. 4 - Eve	rv Dav)	
Address:						. ,, ,	
SS#:Hoi				Intensity: (0 is NO PAIN and 10 is MOST SEVE	DE DAIN		
Work Phone:				·			
Email:				Number #1 - the most severe symptom	Frequency	Intesity	
Responsible Party:				#1 = the most severe symptom Back Pain	1-4	0-10	
				Dizziness			
Physician Name & Address:				Ear Congestion			
_				Ear Pain		<u> </u>	
Referred By:				Eye Pain			
				Facial Pain			
LIST ANY MEDICATION	IS WHIC	н н.	AVE CAUSED	Fatigue			
AN ALLERGIC REACTIO			THE CHOOLD	Headaches			
Y N Antibiotics	Υ	NI	Metals	Jaw Clicking			
Y N Aspirin	Ϋ́	N	Penici <b>ll</b> in	Jaw Joint Noises			
Y N Codeine	Y	N	Plastic	Jaw Locking			
Y N lodine	Υ	Ν		Jaw Pain			
Y N Latex	Υ	N	. 5.	Limited Mouth Opening			
Y N Local anasthetics	Υ	N	Sulfa drugs	Muscle Soreness			
Other allergens:			Muscle Twitching				
			Neck Pain				
			,	Pain when Chewing			
				Ringing in the Ears			
				Shoulder Pain			
				Sinus Congestion			
				Throat Pain			
				Visual Disturbances			
				Other:			
Patient Signature:				Date:			

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