

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.

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

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Muscle relaxants
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sedatives
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Insulin	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> Other: _____		

Patient Signature _____ Date _____

MEDICAL HISTORY

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

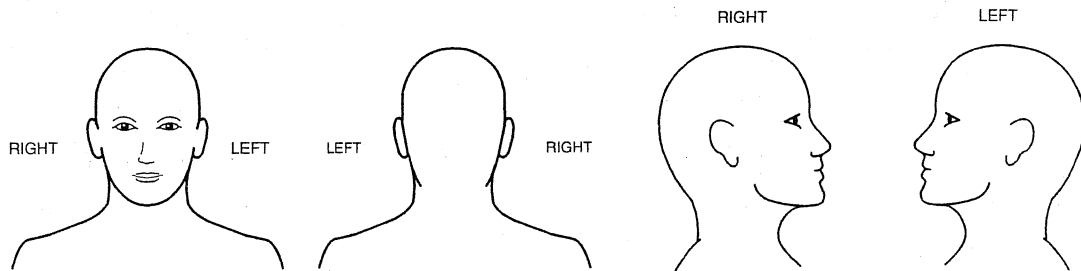
- | | | | | | |
|--|------------------------|--|---------------------|--|----------|
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Motor vehicle accident | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> | Playground incident | <input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

- If accident, date _____
- Injury Y N Unknown
- 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 |
| | | T Tingling |
| SEVERE PAIN | | 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: _____