

Temporomandibular Disorder Questionnaire

Patient Name: _____ Date: _____

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you have grating, clicking or popping in either or both jaws when you chew?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have sensations of stiffness, pressure/blockage, ringing, hissing or buzzing in your ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you ever feel dizzy or faint?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is your jaw painful or locked when you wake up in the morning?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you consider yourself chronically fatigued?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Check any area where you have pain or soreness: | | |
| <input type="checkbox"/> Jaw joints | | |
| <input type="checkbox"/> Upper jaw or teeth | | |
| <input type="checkbox"/> Back of head | | |
| <input type="checkbox"/> Temples | | |
| <input type="checkbox"/> Forehead | | |
| <input type="checkbox"/> Lower jaw or teeth | | |
| <input type="checkbox"/> Chewing muscles | | |
| <input type="checkbox"/> Side of Neck | | |
| <input type="checkbox"/> Behind the eyes | | |
| <input type="checkbox"/> Tongue | | |
| <input type="checkbox"/> _____ | | |
| 7. Is it hard to move your jaw side-to-side, forward or backward?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have difficulty chewing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have back teeth missing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had extensive dental crowns and bridgework?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you clench or grind your teeth during the day or night?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you ever have a headache when you wake up?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you had whiplash injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you worn a cervical collar or had neck traction?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever had a blow to the chin, face or head?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you reached the point at which drugs no longer relieve your symptoms?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does chewing gum start your symptoms?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Does your jaw deviate to the left or right when you open wide?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. When your mouth is wide open, can you insert three fingers into your mouth vertically?..... | <input type="checkbox"/> | <input type="checkbox"/> |

20. Please write a brief narrative of your past medical and dental history (including injuries) pertaining to the jaw joint and any treatment performed (nightguard, splint, bite adjustment, surgery):
