TEMPOROMANDIBULAR JOINT QUESTIONAIRE

Name: _____ Age: ____ Sex: ____ Date:_____

If you can answer YES to the question asked, circle YES.
If you have to answer NO to the question, circle NO. Please answer all questions.

1. Do you have clicking, popping or grating noise in your
   Right jaw joint? YES NO
   Left jaw joint? YES NO

2. When did you first notice the noise? _____
   _____

3. Has the noise recently become more pronounced? YES NO
   When? _____

4. Do you have pain in or around the right joint? YES NO
   Left joint? YES NO

5. When did you first notice the pain? _____
   _____

6. Has the pain recently become more pronounced? YES NO
   When? _____

7. Is the pain worse: Mornings _____ At meals _____
   Evenings _____ No specific time _____

8. Is this pain: Dull _____ Continuous _____
   Stabbing _____ Intermittent _____
   Throbbing _____ Other _____

9. Does the pain sometimes feel like it is in your ear? YES NO

10. Do you think this problem has affected your hearing? YES NO

11. Does your jaw problem interfere with your normal activities? YES NO

12. Are you taking or have you taken medication for this problem? YES NO
    Explain _____
    _____

13. Did anything occur which might be related to the onset of this problem? YES NO
    Explain _____
    _____

14. Do you have difficulty chewing? YES NO
    Because of: Pain in joint _____ Limited opening _____
    Pain in teeth _____ Missing teeth _____
    Clicking _____ Other _____

(Over)

15. Has your mouth ever locked open so you were unable to close it? YES NO
Explain _____
_____
_____

16. Have you had problems opening your mouth wide? YES NO
Explain _____
_____
_____

17. Please indicate the time sequence in which you became aware of the following problems (1st, 2nd, 3rd, etc.) Number only those which apply to you.
Pain _____ Noise _____ Limited opening _____ Locking _____ Other _____

18. Which aspects of your problem concern you the most?
_____
_____

19. Are you aware of clenching your teeth? YES NO

20. Do you grind your teeth? YES NO
When? _____

21. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in immediate family or other stressful events? YES NO

22. Do you think nervous tension seems to affect this problem? YES NO
Explain _____
_____

23. Have you had problems with other joints? YES NO

24. Have you had orthodontic treatment? YES NO
When _____ Where _____

25. Have you had recent dental treatment? YES NO
Explain _____
_____

26. Have you had x-rays taken for this problem? YES NO
When _____ Where _____

27. Have you received previous treatment for this problem? YES NO