

**Optimal Dental**  
**TMJ HEALTH QUESTIONNAIRE**

**Patient name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Chief Concern:** \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

**Pain Symptoms**

Do you get headaches?	Y	N
Do you get migraine headaches?	Y	N
Do you frequently have neck aches or stiff neck muscles?	Y	N
Have you ever had chronic shoulder or back pain?	Y	N
Do you have trouble sleeping soundly?	Y	N
Are your jaws tired when you awaken?	Y	N
Are your teeth sore when you awaken?	Y	N
Do you get headaches in the right or left temple areas?	Y	N
Do you get headaches in the front or back of your head?	Y	N
Do you clench your teeth at night?	Y	N
Do you grind your teeth when asleep?	Y	N
When are your pain symptoms the worst?	_____	
Does anything make you feel better?	_____	
What medications, if any, are you taking?	_____	
How often do you take medication for relief of pain?	_____	
Have your wisdom teeth been extracted?	Y	N

**Trauma or Accidents**

Have you ever had a severe blow to the head or jaw?	Y	N
Any whiplash neck injuries?	Y	N
Have you ever been involved in any serious accidents, such as a car accident?	Y	N
Details:	_____	

**Jaw Joint Symptoms**

Does your jaw feel tired after a big meal?	Y	N
Are there any foods you avoid eating?	Y	N
Do you ever get dizzy?	Y	N
Do you ever feel faint?	Y	N
Do you ever feel nauseated?	Y	N
Is there a family history of jaw joint(TMJ) problems or headache?	Y	N
Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint?	Y	N
Has your jaw ever locked when you were unable to open or close?	Y	N
Do you have difficulty opening wide or yawning?	Y	N
Have you ever had pain in either jaw joint?	Y	N
Does your jaw ache when you open wide?	Y	N

**Ear and Eye Symptoms**

Do you have pain in either ear?	Y	N
Do you suffer from any loss of hearing?	Y	N
Do you have itchiness or stuffiness in either ear?	Y	N
Do you hear ringing, buzzing, or hissing sounds in either ear?	Y	N
Do you wear glasses or contacts?	Y	N
Are there times when your eyesight blurs?	Y	N
Do you get pain in, around or behind either eye?	Y	N

**Breathing**

Do you have allergies?	Y	N
Do you have sinus problems?	Y	N
Do you snore at night?	Y	N
Is your nose stuffed when you don't have a cold?	Y	N
Have you been diagnosed with Sleep Apnea?	Y	N
Have you had a sleep study done at a Sleep Clinic (hospital)?	Y	N