

# Ravi Doctor DDS



## Temporomandibular Joint Questionnaire

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please answer all questions completely.**

1. Which aspects of your condition concern you the most? \_\_\_\_\_

2. Have you received previous treatment for this condition? \_\_\_\_\_  Yes  No

When? \_\_\_\_\_ Where? \_\_\_\_\_

3. Have you ever had a severe impact or trauma to the head, neck, or jaw? \_\_\_\_\_  Yes  No

Which area? \_\_\_\_\_ When? \_\_\_\_\_

Explain details: \_\_\_\_\_

4. Do you have frequent headaches or neck aches? \_\_\_\_\_  Yes  No

What area? \_\_\_\_\_

How frequent? \_\_\_\_\_

How do you control the pain? \_\_\_\_\_

5. Do you have difficult chewing? \_\_\_\_\_  Yes  No

Because of:  Pain in Joint  Limited Opening  Pain in Teeth  Missing Teeth  Clicking  Other

6. Has your mouth ever locked open so you were unable to close it? \_\_\_\_\_  Yes  No

7. Has your mouth ever locked closed? \_\_\_\_\_  Yes  No

Explain details: \_\_\_\_\_

8. Are you aware of clenching your teeth? \_\_\_\_\_  Yes  No

9. Are you aware of grinding your teeth? \_\_\_\_\_  Yes  No

10. Have you had recent dental treatment? \_\_\_\_\_  Yes  No

Which area? \_\_\_\_\_ When? \_\_\_\_\_

Explain details: \_\_\_\_\_

11. Have you had any orthodontic treatment? \_\_\_\_\_  Yes  No

When? \_\_\_\_\_ Where? \_\_\_\_\_

12. Do you think that nervous tension seems to affect this condition? \_\_\_\_\_  Yes  No

Explain details: \_\_\_\_\_

13. Do you experience ringing or other sounds in your ears? \_\_\_\_\_  Yes  No

Explain details: \_\_\_\_\_

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14. Do you have pain in or around the right jaw joint?  Yes  No  
left jaw joint?  Yes  No

15. When did you first notice the pain? \_\_\_\_\_

16. Has the pain recently become more pronounced?  Yes  No

Explain details: \_\_\_\_\_

17. When is the pain worse?  Mornings  Evenings  At Meals  No Specific Time

18. Is the pain:  Dull  Stabbing  Throbbing  Continuous  Intermittent  Other

19. Does the pain sometimes feel like it is in your ears?  Yes  No

20. Do you think the condition has affected your hearing?  Yes  No

21. Does your jaw condition interfere with your normal activities?  Yes  No

22. Are you taking or have you taken medication for this condition?  Yes  No

Explain details: \_\_\_\_\_

23. Do you have clicking, popping, or a grating noise in the right jaw joint?  Yes  No  
left jaw joint?  Yes  No

24. When did you first notice the noise? \_\_\_\_\_

25. Has the noise recently become more pronounced?  Yes  No

Explain details: \_\_\_\_\_

26. Has the noise recently disappeared?  Yes  No

Explain details: \_\_\_\_\_

27. Have you had complications with other joints?  Yes  No

28. Have you had x-rays taken for this condition?  Yes  No

When? \_\_\_\_\_ Where? \_\_\_\_\_

29. Is there any additional information you would like to add that may be helpful? \_\_\_\_\_

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

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