

# Temporomandibular Disorders (TMD)

(Please Print Legibly)

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

Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

**Directions:** Please answer all by checking, circling, or filling in the blank on all that apply.

YES NO

1. Do you have frequent headaches?
2. Do you have pain in or around the **right** jaw joint?
3. Do you have pain in or around the **left** jaw joint?
4. When did you first notice the jaw pain? \_\_\_\_\_
5. Has the pain recently become more severe? If so, when? \_\_\_\_\_
6. The pain is worse in the:  Mornings  Evenings  At Meals  No Specific Time
7. The pain is:  Dull  Stabbing  Throbbing  Continuous  Intermittent  
 Other: \_\_\_\_\_
8. Does the pain sometimes feel like it is in your ear?
9. Do you have clicking, popping, or grating noise in your **right** jaw joint?
10. Do you have clicking, popping, or grating noise in your **left** jaw joint?
11. When did you first notice the noise? \_\_\_\_\_
12. Has the noise become more pronounced recently?
13. Has your hearing worsened since your jaw problem began?
14. Does your jaw problem interfere with your normal activities?
15. Are you taking, or have you taken, medication for this problem? If so, what? \_\_\_\_\_  
\_\_\_\_\_
16. Has anything occurred in your life which might be related to the onset of the problem?  
Explain: \_\_\_\_\_  
\_\_\_\_\_
17. Have you ever had a severe blow or trauma to the head, neck, or jaw?  
Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
18. Do you have difficulty chewing? If so, is this difficulty because of:  
 pain in joint  pain in teeth  clicking  limited opening  missing teeth  
 Other (specify): \_\_\_\_\_

# Temporomandibular Disorders (continued)

YES NO

19. Has your mouth ever locked open so you were unable to close it? If so, when? \_\_\_\_\_  
\_\_\_\_\_
20. Have you had problems opening your mouth wide? If so, please explain: \_\_\_\_\_  
\_\_\_\_\_
21. Are you aware of clenching your teeth? When? \_\_\_\_\_
22. Do you grind your teeth? When? \_\_\_\_\_
23. Has there been recent change in your lifestyle such as, a change in marital status, childbirth, change of employment, death in immediate family, or other stressful events? If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_
24. Do you think nervous tension seems to affect this problem?
25. Have you had problems with other joints?
26. Have you had orthodontic treatment? If so, when? \_\_\_\_\_
27. Have you had recent dental treatment? If so, when? \_\_\_\_\_  
Where? \_\_\_\_\_ Why? \_\_\_\_\_
28. Have you had recent x-rays taken for this problem? If so, when? \_\_\_\_\_  
Where? \_\_\_\_\_