Orthodontic/ TMJ Questionnaire

Patient Name____ **Date**________________________
Chief reason for requesting treatment: (please check all that apply)
☐ Crowding ☐ Overbite ☐ Don't like my smile ☐ Appearance ☐ Better Function ☐ Airway Assessment
☐ Teasing at school ☐ My dentist found the problem ☐ I/We don't see the problem
Bad habits: ☐ Thumb sucking ☐ Tongue Habit ☐ Mouth Breathing
Any other reason?____

Pain Symptoms Do you ever get:
"migraine headaches"? ☐Yes ☐No Headaches in the back you your head? ☐Yes ☐No
Headaches in the right or left temple areas? ☐Yes ☐No "tension headaches"? ☐Yes ☐No
Does your jaw ache when you chew? ☐Yes ☐No When you open wide? ☐Yes ☐No
Do you grind your teeth? ☐Yes ☐No Do you have trouble sleeping soundly? ☐Yes ☐No
When you wake up: have your teeth been sore? ☐Yes ☐No Are your jaws tired? ☐Yes ☐No
Do you frequently have neck aches or stiff neck muscles? ☐Yes ☐No
Have you ever had chronic shoulder or back pain? ☐Yes ☐No Ear pain? ☐Yes ☐No
How often do you take medicine for relief of pain? ☐Never ☐Monthly ☐Weekly ☐Daily

Jaw Joint Symptoms
Does your jaw feel tired after a big meal? ☐Yes ☐No
Are their any foods that you avoid eating? ☐Yes ☐No
Do you feel or hear a "clicking", "popping", or "cracking" noise from either jaw joint? ☐Yes ☐No
Has your jaw ever locked where you were unable to open or close? ☐Yes ☐No
Do you have difficulty opening wide or yawning? ☐Yes ☐No
Have you ever had pain in either jaw joint? ☐Yes ☐No
Is there a history of TMJ problems or headaches in the family? ☐Yes ☐No
Do you ever get dizzy? ☐Yes ☐No Do you ever fell faint? ☐Yes ☐No
Do you ever fell nauseated (sick)? ☐Yes ☐No

Trauma or Accidents
Have you ever had: A severe blow to the head or jaw? ☐Yes ☐No
Whiplash or neck injuries? ☐Yes ☐No Any serious accidents, such as a car accident? ☐Yes ☐No
Please explain any "yes" answers in detail:____

Ear and Eye Symptoms
Do you have itchiness or stuffiness in either ear? ☐Yes ☐No
Do you suffer from any loss of hearing? ☐Yes ☐No
Do you get pain in, around or behind either eye? ☐Yes ☐No
Are there times when your eyesight blurs? ☐Yes ☐No
Do you hear ringing, buzzing, or hissing sounds in either ear? ☐Yes ☐No
Do you hear grating noises in ears (sounds like sand particles rubbing)? ☐Yes ☐No
Do you were glasses or contacts? ☐Yes ☐No

Breathing
Do you have allergies? ☐Yes ☐No Do you have sinus problems? ☐Yes ☐No
Do you snore at night? ☐Yes ☐No Is your nose stuffed when you don't have a cold? ☐Yes ☐No
Have you ever had tubes in your ears? ☐Yes ☐No

Patient/Legal Guardian's Signature:_________________________________Date:________________