**Terrance A Bianco,** **DMD, FRCD(C)**
CERTIFIED SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

# Temporomandibular Joint Questionnaire

DIRECTIONS:
If you can answer **YES** to the question asked, please check the box next to **YES**
If you hvae to answer **NO** to the question asked, please check the box next to **NO**

**Answer all questions.**

| Last | First | Age | Sex | Date |
|---|---|---|---|---|
| | | | | |

**1. Do you have a 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 around**
the right joint? ........................................ Yes No
the 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 the pain:** Dull Stabbing Throbbing Continuous Intermittent 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 taken medication for this problem?** ........................................ Yes No

**Explain:** ______________________

______________________

______________________

**13. Did anything accur 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 |

15. **Has your mouth ever locked open so you were unable to close it?** ........ Yes No

**Explain:** ____________________

____________________

____________________

16. **Have you ever 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 problems which apply to you.**

_____ Pain _____ Noise _____ Limited Opening _____ Locking _____ Other

18. **Which aspects of your problem concern you the most?:** ____________________

19. **Are you aware that your 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