ORTHODONTICS
by Dr. Mark D. Paschen
Baraboo • Mauston

Name: _____

Date: _____

TMJ QUESTIONNAIRE

1. **Do you have jaw joint (TMJ) pain?** Yes ___ No ___
   If yes, is the pain: Mild ___ Moderate ___ Severe ___
2. **Do you have TMJ noises when you open and close your mouth?** Yes ___ No ___
   If yes, do you experience: Clicking ___ Popping ___ Grinding ___
   Are the noises: Mild ___ Moderate ___ Severe ___
3. **Have you had TMJ noises in the past?** Yes ___ No ___
   If yes, when did your jaw joint problems begin? Age ____ Year _____
   What started your jaw joint problems? Injury ___ Disease ___ Unknown ___
   Explain: _____
4. **Have you had previous TMJ surgery?** Yes ___ No ___
   If yes, were the procedures on the: Right ___ Left ___ Both ____
5. **Have you noticed your jaw alignment or your bite changing?** Yes ___ No ___
   If yes, is the change: Mild ___ Moderate ___ Severe ___
6. **Do you grind your teeth when asleep?** Yes ___ No ___
7. **Do you get headaches?** Yes ___ No ___
   If yes, are your headaches: Mild ___ Moderate ___ Severe ____
   Are your headaches worse in the: Morning ___ Afternoon ___ Evening ___ Night ___
   How many headaches: Per Week ____ Per Month ____
   When did the headaches first begin? _____
8. **Do you have neck, shoulder, or back pain?** Yes ___ No ___
   If yes, is the pain: Mild ___ Moderate ___ Severe ___
9. **Do you get earaches?** Yes ___ No ___
   If yes, are your earaches: Mild ___ Moderate ___ Severe ___
   In addition, how often do you experience earaches: Occasionally ___ Moderately ___ Frequently ___ Continuously ___
10. **Do you get ringing in your ears?** Yes ___ No ___
    If yes, is the ringing: Mild ___ Moderate ___ Severe ___
    In addition, how often do you experience the ringing: Occasionally ___ Moderately ___ Frequently ___ Continuously ___
11. **Do you get lightheadedness or dizziness:** Yes ___ No ___
    If yes, is the lightheadedness or dizziness: Mild ___ Moderate ___ Severe ___
    In addition, how often do you experience the lightheadedness or dizziness:
    Occasionally ___ Moderately ___ Frequently ___ Continuously ___
12. **How often do you take medicine for relief of pain?** Never ___ Occasionally ___ Daily ___ Weekly ___

Circle the number that best describes your situation:

13. **Rate your jaw function for opening, side to side movement and chewing:** (Please Circle)
    Normal Function 0 1 2 3 4 5 6 7 8 9 10 No Function/Jaws Frozen
14. **What is your chewing ability?** (Please Circle)
    No Restriction/Chew Anything 0 1 2 3 4 5 6 7 8 9 10 Liquids Only/Can't Chew
15. **How much does your jaw problem affect your ability to carry out normal life activities?** (Please Circle)
    No Interference 0 1 2 3 4 5 6 7 8 9 10 Totally Disable