Joseph Sarkissian DDS 818-247-7828

TMJ HEALTH QUESTIONNAIRE

NAME ______________________ **DATE** ____________

CHIEF CONCERN ______________________

DATE OF ONSET ______________________

PAIN SYMPTOMS

Do you get headaches? Y ☐ N ☐
Do you get migraine headaches? Y ☐ N ☐
Do you frequently have neck aches or stiff neck muscles? Y ☐ N ☐
Have you ever had chronic shoulder or back pain? Y ☐ N ☐
Do you have trouble sleeping soundly? Y ☐ N ☐
Are your jaws tired when you awaken? Y ☐ N ☐
Are your teeth sore when you awaken? Y ☐ N ☐

Have your wisdom teeth been extracted? Y ☐ N ☐

Do you get headaches in the right or left temple areas? Y ☐ N ☐
Do you get headaches in the front or back of your head? Y ☐ N ☐
Do you clench your teeth during the day? Y ☐ N ☐
Do you clench your teeth at night? Y ☐ N ☐
Do you grind your teeth when asleep? Y ☐ N ☐

When are your pain symptoms the worst?

____

Does anything make you feel better?

____

What medications, if any, are you taking? ______________________

How often do you take medication for relief of pain? ______________________

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y ☐ N ☐
Any whiplash neck injuries? Y ☐ N ☐

Have you ever been involved in any serious accidents, such as a car accident? Y ☐ N ☐
Details

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y ☐ N ☐
Are there any foods you avoid eating? Y ☐ N ☐
Do you ever get dizzy? Y ☐ N ☐
Do you ever feel faint? Y ☐ N ☐
Do you ever feel nauseated? Y ☐ N ☐
Is there a family history of jaw joint (TMJ) problems or headaches? Y ☐ N ☐
Does your jaw ache when you open wide? Y ☐ N ☐

Do you feel or hear a ‘clicking’, ‘popping’ or ‘cracking’ noise from either jaw joint? Y ☐ N ☐
Has your jaw ever locked when you were unable to open or close? Y ☐ N ☐
Do you have difficulty opening wide or yawning? Y ☐ N ☐
Have you ever had pain in either jaw joint? Y ☐ N ☐

EAR AND EYE SYMPTOMS

Do you have pain in either ear? Y ☐ N ☐
Do you suffer from any loss of hearing? Y ☐ N ☐
Do you have itchiness or stuffiness in either ear? Y ☐ N ☐
Do you hear ringing, buzzing, or hissing sounds in either ear? Y ☐ N ☐

Do you wear glasses or contacts? Y ☐ N ☐
Are there times when your eyesight blurs? Y ☐ N ☐
Do you get pain in, around or behind either eye? Y ☐ N ☐

BREATHING

Do you have allergies? Y ☐ N ☐
Do you have sinus problems? Y ☐ N ☐
Do you snore at night? Y ☐ N ☐
Have you had a sleep study done at a Sleep Clinic (hospital)? Y ☐ N ☐

Is your nose stuffed when you don’t have a cold? Y ☐ N ☐
Have you been diagnosed with Sleep Apnea? Y ☐ N ☐