

TMD Questionnaire

PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION. IF YOU HAVE ANY QUERIES PLEASE ASK ONE OF OUR TEAM MEMBERS FOR HELP.

PERSONAL HISTORY:

- 1.DATE: / /
- 2.NAME:
- 3.DATE OF BIRTH: / /
- 4.GENDER: MALE / FEMALE

IF YOU ARE FEMALE DO YOU HAVE CHILDREN: YES / NO

MEDICAL HISTORY:

- 5. WHAT IS YOUR CHIEF COMPLAINT?
- 6. HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING DISORDERS?
HYPERTENSION / ATHRTTIS J GOUT J MUSCLE DYSFUNCTION J OTHER:
- 7. **SYMPTOMS:**TICK IF APPLIES AND GIVE DETAILS IF POSSIBLE -

CONDITION	FREQUENCY	LOCATION	TIME
NECKACHE			
SHOULDER PAIN			
BACK PAIN UPPER/LOWER			
EARACHE			
EAR/SINUS CONGESTION			
HEARING LOSS			
TINNITIS			
DIZZINESS			
SORE THROAT			
TOOTHACHE			
JOINT PAIN			

8. ARE YOU TAKING ANY MEDICATION? YES / NO
IF YES, PLEASE LIST THEM:

9. ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR? YES / NO
IF YES, PLEASE PROVIDE THEIR CONTACT DETAILS:

10. HAVE YOU EVER EXPERIENCED ANY TRAUMATIC INJURY TO YOUR HEAD, JAW, NECK OR BACK? YES / No IF YES, PLEASE DESCRIBE THE ACCIDENT.

11. DO YOU SUFFER FROM HEADACHES? **YES / NO**

IF YES, PLEASE TICK ONE OF THE FOLLOWING ANSWERS:

FREQUENCY -	ONCE OR TWICE A DAY MANY TIMES A DAY ALMOST CONSTANTLY ONLY WHEN I EAT	DURATION - MANY HOURS AN HOUR OR SO ONLY A FEW MINUTES
SEVERITY -	MILD MODERATE SEVERE ACUTE, TO THE POINT I CANNOT FUNCTION	

12. DO YOU SMOKE OR USE OTHER FORMS OF TOBACCO? **YES / NO**

13. DO YOU DRINK COFFEE, TEA OR OTHER DRINKS CONTAINING CAFFEINE? **YES/ NO** IF YES,
PLEASE SPECIFY:

14. DO YOU CLENCH OR GRIND YOUR TEETH DURING THE DAY? **YES /NO**

15. HAVE YOU BEEN MADE AWARE OF CLENCHING OR GRINDING YOUR TEETH DURING THE NIGHT?
YES/ NO

16. DO YOU OFTEN WAKE UP DURING THE NIGHT? **YES / NO**

17. ARE YOUR JAWS OR TEETH TIRED WHEN YOU AWAKEN? **YES / NO**

18. DO YOU FEEL REFRESHED WHEN YOU AWAKEN IN THE MORNING? **YES / NO**

19. DO YOU SUFFER FROM CHRONIC HEADACHES OR NECK AND SHOULDER PAINS? **YES / NO**

20. DO YOU NOW, OR HAVE YOU EVER HAD, PAIN IN YOUR JAW JOINT OR THE SIDES OF YOUR
FACE PARTICULARLY AROUND THE EAR? **YES / NO**

21. DO YOUR JAWS EVER CLICK OR POP WHEN YOU OPEN OR CLOSE YOUR MOUTH, OR
WHEN YOU EAT? **YES / NO**

22. DOES YOUR JAW HURT WHEN YOU OPEN, CLOSE OR EAT? **YES / NO**

23. DO YOU TEND TO CHEW ON ONLY ONE SIDE OF YOUR MOUTH? **YES / NO**

24. HAVE YOU EVER HAD ANY DENTAL WORK (CROWNS, BRIDGES, FILLINGS, etc.) THAT STOPPED
YOUR TEETH BITING NORMALLY TOGETHER OR FELT "IN THE WAY"? **YES / NO**

AESTHETIC EVALUATION

25. ARE YOU SATISFIED WITH YOUR TEETH AND THEIR APPEARANCE? **YES / NO**

26. ARE YOU SELF-CONSCIOUS ABOUT YOUR TEETH WHEN YOU SMILE? **YES / NO**

27. DO YOU EVER COVER YOUR SMILE WITH YOUR HAND? **YES / NO**

28. DO YOU WISH YOUR TEETH WERE WHITER? **YES / NO**

29. DO YOU WISH YOUR TEETH WERE SHAPED DIFFERENTLY? **YES / NO**

30. DO YOU HAVE ANY DISGULOURED TEETH? **YES / NO**

31. HAVE COSMETIC DENTAL PROCEDURES EVER SEEN RECOMMENDED TO YOU? **YES / NO**

32. IS THERE ANY INFORMATION THAT YOU FEEL WE NEED TO KNOW? **YES / NO**
IF YES, PLEASE SPECIFY: