Temporomandibular Joint History

NAME________________________________________________  DATE______

Please answer the following questions by indicating frequency according to the following guidelines:

Always = A  =  every or almost every night or day
Often = O =  at least once a week but less than "always"
Seldom = S =  less than once a week
Never = N =  never during a usual night or day

Circle the appropriate letter.

Do you have any of the following symptoms?

1. Headaches............................................................................... A  O  S  N
2. Dizziness................................................................................... A  O  S  N
3. Lightheadedness......................................................................... A  O  S  N
4. Ringing or buzzing in the ear..................................................... A  O  S  N
5. Sinuses or ears feel filled.......................................................... A  O  S  N
6. Numbness or tingling of fingertips.......................................... A  O  S  N
7. Backaches (upper or lower)...................................................... A  O  S  N
8. Neck aches............................................................................... A  O  S  N
9. Sounds from jaw joint (clicking, etc..)..................................... A  O  S  N
10. Difficulty opening or closing mouth....................................... A  O  S  N
11. Pain from the jaw joint............................................................ A  O  S  N
12. Pain in the facial muscles......................................................... A  O  S  N
13. Pain in the upper or lower teeth.............................................. A  O  S  N
14. Easily fatigued at the end of the day..................................... A  O  S  N
15. Sore throat............................................................................... A  O  S  N
16. Difficulty in remembering and learning............................... A  O  S  N
17. Inability to fully open your mouth......................................... A  O  S  N
18. Pain in the eye or visual problems.......................................... A  O  S  N
19. Encounter stressful situations.............................................. A  O  S  N

Additional Comments:

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