RIVERVIEW
FAMILY DENTAL

TMJ Patient Questionnaire

Patient Name: _____
Date: _____

YES NO

_____ _____1)Do you have frequent or regular headaches?
upon awakening
Late afternoon

_____ _____ 2) Are your jaw muscles sore or tender?

_____ _____ 3) Are you joints sore or tender when you eat or chew?

_____ _____ 4) Have you ever received an injury to your jaw or face?
If yes: Describe:
_____
_____
_____

_____ _____ 5) Do your joints make any noise such as snapping, clicking or popping?

_____ _____ 6) Do your joints lock when you are trying to open or close?

_____ _____7) Do you have any teeth that are sensitive, sore, aching, or uncomfortable?

_____ _____8) Have you ever worn a splint or night guard?
If yes: How many? _____
_____ _____9) Are you taking or have you taken any medication for these symptoms?

_____ ____10) Have you ever seen a dentist or a TMJ specialist for treatment of any of above symptoms? If yes: How many?_____

100 4th Street S., Suite 304, Fargo, ND P: 701.235.6075 F: 701.239.0140
W: riverviewfamilydental.com E: info@riverviewfamilydental.com