

Date: \_\_\_\_\_

## FACIAL PAIN AND TMJ QUESTIONNAIRE

In order for us to provide you with optimum care in the diagnosis and treatment of your condition, your cooperation is needed in providing us with all the necessary information. Please complete the following questions as accurately and completely as possible and return to this office.

Name: \_\_\_\_\_

1. What is the nature of your pain or problems? List the 4 major symptoms you would like relief from (i.e. Headaches, teeth hurt, jaw clicking or locking, jaw pain, ear pain, neck soreness, etc.).  
Please rate the intensity of pain in these areas on a scale from 1 to 10  
10= extremely severe pain
  - a.
  - b.
  - c.
  - d.
  
2. Are you bothered with frequent headaches? Yes\_\_\_ no\_\_\_
  - a. If so, where?
  - b. How often (times per week)
  - c. How intense (scale 1-10, 10 = severe)
  - d. When do they occur?
  - e. How long does each episode last?
  - f. What makes it better?
  - g. What makes it worse?
  - h. When did this problem first begin?
  - i. Can you relate the beginning of your headaches to anything?
  - j. What type of headache do you have? Migraine\_\_\_ muscle tension\_\_\_ sinus\_\_\_ cluster\_\_\_ don't know\_\_\_
  
3. List the other treatments you have received for your problem?
  - a.
  - b.
  - c.
  
4. Were any of these treatments effective and for how long?

5. List all medications you are now taking or have taken for this problem.  
Describe their effectiveness.
  
6. Do you grind or clench your teeth? Yes\_\_\_ no\_\_\_ Don't know\_\_\_  
( ) daytime ( ) nighttime How often?
  
7. Have you had orthodontic treatment? Yes\_\_\_ no\_\_\_  
age\_\_\_ how long\_\_\_ why?
  
8. Did you wear a retainer? Yes\_\_\_ no\_\_\_ Bite splint? Yes\_\_\_ no\_\_\_  
upper\_\_\_ lower\_\_\_ How long?
  
9. Have you ever received an injury to your face or lower jaw? Yes\_\_\_ no\_\_\_  
When?  
Does your current problem relate to this injury?  
Please describe:
  
10. Have you ever had any sinus problems? Yes\_\_\_ no\_\_\_  
Describe:
  
11. Check your usual sleeping position.  
( ) back ( ) stomach ( ) left side ( ) right side
  
12. Do you have any problems with sleeping? Yes\_\_\_ no\_\_\_  
Describe:
  
13. Do you notice noise in you jaw joints? Yes\_\_\_ no\_\_\_  
( ) right ( ) left  
How often?  
When did it start?  
Describe:

14. Does your lower jaw ever lock? Yes\_\_\_ no\_\_\_  
prevents - ( ) full opening ( ) full closing  
How often?  
When does this occur?
15. Do your jaw joints ever hurt? Yes\_\_\_ no\_\_\_ occasionally\_\_\_  
All the time\_\_\_ ( ) right ( ) left
16. How does stress effect you?

Rate yourself

Totally laid back |---|---|---|---|---|---|---|---|---|---| totally stressed out  
1 10  
Are you able to relax at home? Work?  
Are you presently under a great deal of stress? (job,family,school.....)

17. Do you frequently have neck aches? ( ) yes ( ) no
18. Do you feel your ears are occasionally "stuffed up"? ( ) yes ( ) no
19. Do you hear a ringing sound in your ears? R/L ( ) yes ( ) no
20. Do you have pain your ears? R/L ( ) yes ( ) no
21. Do you chew gum? How often? ( ) yes ( ) no
22. Do you chew ice frequently? ( ) yes ( ) no
23. Do you chew on the left\_\_\_ or right\_\_\_ side of your mouth?
24. Do you drink coffee? How much?\_\_\_\_\_ ( ) yes ( ) no
25. After eating do you have a problem keeping food down? ( ) yes ( ) no
26. Does your bite feel uncomfortable? ( ) yes ( ) no
27. Has a dentist told you that you have worn teeth? ( ) yes ( ) no
28. Do you have a high incidence of cracked teeth or  
Broken fillings? ( ) yes ( ) no
29. Does it hurt to eat hard or chewy foods? ( ) yes ( ) no
30. Do you have difficulty when opening your mouth wide? ( ) yes ( ) no
31. Have you ever had arthritis? ( ) yes ( ) no
32. Do you have any difficulty swallowing? ( ) yes ( ) no
33. Do you take aspirin frequently? How much\_\_\_\_\_ ( ) yes ( ) no
34. Do you have sensitive teeth? Describe: ( ) yes ( ) no
35. Do you smoke? How much\_\_\_\_\_ ( ) yes ( ) no
36. Do you eat breakfast? ( ) yes ( ) no
37. Do you get dizzy frequently? ( ) yes ( ) no
38. Do you frequently experience an upset stomach  
Or heartburn? ( ) yes ( ) no
39. Do your jaw muscles become tired frequently? ( ) yes ( ) no

- 40. Do you have any pain around your eyes? ( ) yes ( ) no
- 41. Have you ever been diagnosed or treated for anxiety? ( ) yes ( ) no
- 42. Have you ever been diagnosed or treated for depression? ( ) yes ( ) no
- 43. Do you exercise regularly? ( ) yes ( ) no
- 44. Does your pain prevent you from being able to work? ( ) yes ( ) no
- 45. Are you afraid that your problem is serious? ( ) yes ( ) no
- 46. What do you desire from treatment?

Please bring this questionnaire with any old x-rays, dental models and/or old bite splints to your evaluation appointment. All material will be used to help in determining the proper diagnosis and treatment.

Frank E. Seaman, DDS, MS, FACP

Board Certified Prosthodontist

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