Jaw Joint (TMJ) Function/Headache/Sleep/Misc.

Name:____ **Date:**_____________

JAW JOINT (TMJ) FUNCTION:

1. Are you aware of jaw joint sounds? NO/YES
   If so, what kind of sounds? popping/clicking/grating
   Which side? Right/Left/Both
   Where on face? ____
2. Did you ever have jaw joint sounds? NO/YES
   If so, what kind of sounds? Popping/clicking/grating
   Which side? Right/Left/Both
   Where on face? ____
3. Do you ever have pain or soreness in front of your ears? NO/YES
4. Do you ever have ear pain? NO/YES
5. Do you wake up with your jaws sore or tired?
   If so, which side? Right/Left/Both
6. Do you ever have difficulty opening widely? NO/YES
7. Do you avoid eating certain foods because of pain/discomfort in your jaws? NO/YES
8. Have you ever been diagnosed with TMJ/TMD? NO/YES
   If so, when was the diagnosis and what treatments have you had?

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HEADACHE:

1. Do you ever get headaches? NO/YES
   If so, how often? ____
2. Has there been a change in your headache pattern? NO/YES
3. Does anything trigger your headaches? NO/YES
   If yes, what? ____
4. To what degree do your headaches effect your life? ____________________________
5. On a scale of 1-10, what is the range of your headaches? __________________________
6. Have you been evaluated or treated for your headaches? NO/YES
   If YES, what was the diagnosis ?____________________________________
   If YES, what treatments have you received? ______________________________

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SLEEP:

1. Do you snore? NO/YES
2. Do you have high blood pressure? NO/YES
3. Has anyone reported that you choke or gasp for air while sleeping? NO/YES
4. Do you awake refreshed? NO/YES
5. Are you excessively tired during the day? NO/YES

HAVE YOU EVER HAD:

1. Bruxism/clenching/grinding of the teeth? NO/YES
2. Bite adjustments? NO/YES
3. Any oral appliances/nightguards? NO/YES
4. Periodontal (gum) treatments? NO/YES
5. Orthodontic treatments? NO/YES
6. Oral Surgery treatments? NO/YES