TMJ QUESTIONNAIRE

Name: Date:

I. MEDICAL / DENTAL HISTORY

A. General Health:

1. Physical ☐ Good ☐ Fair ☐ Poor

2. Emotional ☐ Good ☐ Fair ☐ Poor

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

☐ **B.** Do you have a personal physician?
☐ **C.** Are you currently under the care of a physician?
☐ **D.** Have you ever been seriously ill?
☐ **E.** Have you been hospitalized in the past 5 years?
☐ **F.** Have you ever had a major operation?
☐ **G.** *Women:* Are you pregnant?
☐ **H.** Has there been any change in your general health in the last year?
☐ **I.** Has there been a major weight loss, without dieting, in recent months?
☐ **J.** Worried about receiving medical/dental treatment?

K. Have you now, or in the past, experienced any of the following conditions?

☐ Allergies
☐ Addiction
☐ Anemia (low blood cell count)
☐ Arthritis
☐ Asthma
☐ Arteriosclerosis
☐ Bleeding Problems
☐ Blood Diseases
☐ Blood Pressure–high
☐ Blood Pressure–low
☐ Blood Transfusions
☐ Bone Disorder
☐ Breathing or Lung Disorder
☐ Cancer
☐ Chronic pain condition
☐ Diabetes
☐ Dizziness
☐ Drug/substance abuse
☐ Epilepsy
☐ Endocrine problems
☐ Female problems
☐ Gastrointestinal (GI) problems (ulcers)
☐ Genitourinary problems
☐ Heart Disease
☐ Hearing disorder, ringing ears
☐ Hepatitis
☐ HIV / AIDS / ARC (circle)
☐ Jaundice
☐ Kidney Disease
☐ Migraine headaches
☐ Musculo–skeletal disorder
☐ Neurological disorder
☐ Psychiatric disorder
☐ Rheumatic fever
☐ Sleep disturbance (snoring, night gasping)
☐ Stroke
☐ Venereal Disease
☐ OTHER:

L. Medications currently taken by the patient?

☐ None
☐ Antibiotics
☐ Birth control pills/hormones
☐ Diet Pills (Diuretics)
☐ Heart Pills (Digitalis, etc.)
☐ Insulin
☐ Muscle Relaxants (Valium, etc.)
☐ Pain Pills (Demerol, Codeine, etc.)
☐ Sleeping pills (Barbiturates)
☐ Tranquilizers (Valium, etc.)
☐ OTHER:

RONCONE ORTHODONTICS

M. Allergies to medicine and/or food?

- ☐ None
- ☐ Antibiotics
- ☐ Dairy Products
- ☐ Dental anesthetics
- ☐ Dyes in foods
- ☐ Metals
- ☐ Pain pills
- ☐ Wheat, cereals
- ☐ OTHER:

II. CRANIOFACIAL SYMPTOMS OF THE HEAD, NECK AND FACE

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

- ☐ 1. Bleeding gums and/or gum disease?
- ☐ 2. Crowns on teeth and/or caps?
- ☐ 3. Do you chew gum regularly?
- ☐ 4. Do you feel that there is not enough room for your tongue?
- ☐ 5. Do you have missing back teeth without replacement?
- ☐ 6. Oral Surgery?
- ☐ 7. Orthodontic treatment?
- ☐ 8. Periodontal disease (Pyrrohea)?
- ☐ 9. Sore or painful teeth?
- ☐ 10. Teeth sensitive to cold and/or hot?
- ☐ 11. Teeth badly worn?
- ☐ 12. Teeth have been ground by dentist?
- ☐ 13. Teeth feel very loose?
- ☐ 14. Teeth extracted within the past three years?
- ☐ 15. TMJ (jaw joint) treatment?
- ☐ 16. Treated for a bad bite?
- ☐ 17. Wisdom teeth removed?
- ☐ 18. Do you have frequent canker sores or cold sores?

A. CRANIOFACIAL PAIN

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

- ☐ 1. Do you have generalized facial pain?
- ☐ 2. Is there constant or recurring pain on the LEFT side?
- ☐ 3. Is there constant or recurring pain on the RIGHT side?
- ☐ 4. Does the pain or discomfort disturb your sleep?
- ☐ 5. Would you describe the pain as a dull, aching sensation?
- ☐ 6. Would you describe the pain as stabbing, sharp, severe sensation?
- ☐ 7. Do you suffer from chronic headaches?
- ☐ 8. Do you ever have migraine headaches?
- ☐ 9. Do you have tension headaches?
- ☐ 10. Do you have headaches in the LEFT temple?
- ☐ 11. Do you have headaches in the RIGHT temple?
- ☐ 12. Do you have headaches in the back of the head?
- ☐ 13. Are there times that the pain/problems are less or gone completely?
- ☐ 14. Do you have pain in your teeth on awakening?
- ☐ 15. Do your teeth hurt from clenching or chewing?
- ☐ 16. Does your jaw ache when you chew?
- ☐ 17. Does your jaw hurt when you open wide or take a big bite?
- ☐ 18. Does it hurt to open wide now?

RONCONE ORTHODONTICS

☐ 19. Do you have ear pain?
☐ 20. Do you have pain in front of the ears?
☐ 21. Is the degree of pain same in morning as evenings?
☐ 22. Do you have chronic stiff neck?
☐ 23. Do you have neck aches (neck pain)?
☐ 24. Have you ever had chronic shoulder or back pain?
25. When are your symptoms worse?
- ☐ Upon rising in the morning
- ☐ At work
- ☐ At the end of the workday
- ☐ At home
- ☐ At school

☐ 26. Have you ever been treated for pain?
☐ 27. Have you ever had injections or nerve blocks for pain?
☐ 28. Did any of the injections bring relief from pain?
☐ 29. Have you ever been operated on to relieve pain?
☐ 30. Did the operation bring relief from pain?
31. How often do you take medicine for the relief of pain?
- ☐ Never
- ☐ Seldom (a few times a year)
- ☐ Occasionally (once a month)
- ☐ Often (weekly)
- ☐ Frequently (daily)

B. BREATHING PROBLEMS
Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:
☐ 1. Allergies?
☐ 2. Does your nose feel stuffy when you don't have a cold?
☐ 3. Does your nose run when you don't have a cold?
☐ 4. Sinus problems?
☐ 5. Do you snore?
☐ 6. Mouth breather?
☐ 7. Do you have sleep apnea?

C. EYE PROBLEMS
Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:
☐ 1. Pain in, around, or behind eyes?
☐ 2. Eyesight blurs?
☐ 3. Eyelid tics (twitches)?
☐ 4. Eyes blink excessively?
☐ 5. Do your eyes water most of the time (tearing)?

D. EAR PROBLEMS
Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:
☐ 1. Earaches or ear pain?
☐ 2. Hearing loss?
☐ 3. Grating noise in ears (like sand particles)?
☐ 4. Itchiness in ears?
☐ 5. Stuffiness in ears?
☐ 6. Ringing, hissing, or buzzing sounds in ears?
☐ 7. Whooshing or throbbing sound in ears?

RONCONE ORTHODONTICS

E. EQUILIBRIUM PROBLEMS

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

☐ 1. Do you feel lightheaded or dizzy?
☐ 2. Often feel like vomiting or nauseated?

F. POSTURE PROBLEMS

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

☐ 1. Do you have backaches?
☐ 2. Do you have an abnormal curvature of the spine?
☐ 3. Are your legs of unequal lengths?
☐ 4. Do you have problems sitting still for prolonged time?
☐ 5. Do you cradle the phone between your head and shoulders?
☐ 6. Does your work involve typing/word processing?
7. Do you wear high heels?
   ☐ Seldom
   ☐ Occasionally
   ☐ Frequently

G. LIFESTYLE PROBLEMS

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

☐ 1. Are you under a lot of stress?
☐ 2. Do you bite your nails, tongue, or lips?
☐ 3. Take any mood affecting drugs or stimulants?
☐ 4. Do you exercise regularly?
☐ 5. Do you usually eat breakfast?
☐ 6. Do you work more than 40 hours a week?
☐ 7. Do you overeat?

H. JAW (TMJ) SYMPTOMS

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

☐ 1. Have you ever been treated for jaw joint problems, or facial muscle spasms?
☐ 2. Do you have difficulty in chewing your food?
☐ 3. Do you grind your teeth during the night?
☐ 4. Has anyone told you that you grind your teeth?
☐ 5. Are you aware of clenching your teeth during the day?
☐ 6. Are you aware of clenching your teeth during the night?
☐ 7. Are there times when you can't open your mouth widely?
☐ 8. Do you have difficulty in opening your mouth widely?
☐ 9. Does it hurt to open your mouth widely?
☐ 10. Does your mouth go to one side when fully opened?
☐ 11. Has your jaw ever locked or were you unable to open or close your mouth?
☐ 12. Have you had pain in your jaw joint?
☐ 13. Do you hear sounds in your jaw joint?
☐ 14. Do you hear grating sounds in your jaw joint?
☐ 15. Do you hear or feel a clicking or popping in your jaw joint?
☐ 16. Does your jaw make clicking or popping sounds when you chew?
☐ 17. Does your jaw feel tired after a big meal?
☐ 18. Have you experienced numbness of shoulders, arms, hands, or fingers?
☐ 19. Do you have pain in your neck and/or shoulders?

RONCONE
ORTHODONTICS

I. TRAUMA RELATED PROBLEMS

Check box if answer to the question is **YES**. If the box is *not selected* your answer is NO:

- ☐ 1. Accident or trauma to face?
- ☐ 2. Accident or trauma to jaw?
- ☐ 3. Accident or trauma to head?
- ☐ 4. Have you ever received a severe blow to the side of the head or jaw?
- ☐ 5. Accident or trauma to neck?
- ☐ 6. Whiplash or neck injury?
- ☐ 7. Have you worn a cervical traction neck collar?
- ☐ 8. Has there been a strain or stretching of the jaw while yawning, chewing, or opening the mouth wide?
- ☐ 9. Have you experienced a fall within the last two years?

☐ **J.** Are there any other significant medical or dental problems? Please explain:

III. PRACTITIONERS

Please indicate which Practitioners you **Have Seen** or are **Now Seeing** *since your pain began* for treatment and *relief of pain*.

	Have Seen	Now Seeing
1.	☐ Acupuncturists	☐ Acupuncturists
2.	☐ Allergist	☐ Allergist
3.	☐ Anesthesiologist	☐ Anesthesiologist
4.	☐ Cardiologist (heart)	☐ Cardiologist (heart)
5.	☐ Chiropractor	☐ Chiropractor
6.	☐ Clergyman	☐ Clergyman
7.	☐ Dentist	☐ Dentist
8.	☐ Dermatologist (skin)	☐ Dermatologist (skin)
9.	☐ Dietician	☐ Dietician
10.	☐ E.N.T	☐ E.N.T
11.	☐ Endocrinologist	☐ Endocrinologist
12.	☐ Faith Healer	☐ Faith Healer
13.	☐ Family Physician	☐ Family Physician
14.	☐ Gynecologist/Obstetrician	☐ Gynecologist/Obstetrician
15.	☐ Hypnotist	☐ Hypnotist
16.	☐ Internist	☐ Internist
17.	☐ Naturopath	☐ Naturopath
18.	☐ Neurologist	☐ Neurologist
19.	☐ Neurosurgeon	☐ Neurosurgeon
20.	☐ Nutritionist	☐ Nutritionist
21.	☐ Ophthalmologist (eyes)	☐ Ophthalmologist (eyes)
22.	☐ Optometrist	☐ Optometrist
23.	☐ Orthopedist (bones, joints)	☐ Orthopedist (bones, joints)
24.	☐ Orthodontist	☐ Orthodontist
25.	☐ Osteopathic physician	☐ Osteopathic physician
26.	☐ Pediatrician (children)	☐ Pediatrician (children)
27.	☐ Physical therapist	☐ Physical therapist
28.	☐ Physiatrist	☐ Physiatrist
29.	☐ Plastic Surgeon	☐ Plastic Surgeon
30.	☐ Proctologist	☐ Proctologist
31.	☐ Psychiatrist	☐ Psychiatrist

32. ☐ Have Seen Psychologist	☐ Now Seeing Psychologist
33. ☐ Have Seen Radiologist	☐ Now Seeing Radiologist
34. ☐ Have Seen Rheumatologist	☐ Now Seeing Rheumatologist
35. ☐ Have Seen Surgeon	☐ Now Seeing Surgeon
36. ☐ Have Seen Other 1:	☐ Now Seeing Other 1:
37. ☐ Have Seen Other 2:	☐ Now Seeing Other 2:

IV. PAIN SUMMARY

Please identify your areas of pain indicating **Right And / Or Left** that you ***presently*** or ***frequently*** experience, if both sides are involved, mark Left and Right, where appropriate:

1. ☐ Left Top of head	☐ Right Top of head
2. ☐ Left Back of head	☐ Right Back of head
3. ☐ Left Frontal headache	☐ Right Frontal headache
4. ☐ Left Eye and eyebrow	☐ Right Eye and eyebrow
5. ☐ Left Temporal headache	☐ Right Temporal headache
6. ☐ Left Jaw and cheek	☐ Right Jaw and cheek
7. ☐ Left Ear and jaw joint area	☐ Right Ear and jaw joint area
8. ☐ Left Toothache	☐ Right Toothache
9. ☐ Left Front of neck and throat	☐ Right Front of neck and throat
10. ☐ Left Side of neck	☐ Right Side of neck
11. ☐ Left Back of neck	☐ Right Back of neck
12. ☐ Left Upper Thoracic of back	☐ Right Upper Thoracic of back
13. ☐ Left Mid-Thoracic of back	☐ Right Mid-Thoracic of back
14. ☐ Left Lower back	☐ Right Lower back
15. ☐ Left Back of the shoulder	☐ Right Back of the shoulder
16. ☐ Left Front of shoulder	☐ Right Front of shoulder
17. ☐ Left Back of arm	☐ Right Back of arm
18. ☐ Left Front of arm	☐ Right Front of arm
19. ☐ Left Upper chest area	☐ Right Upper chest area

V. BITE AND TOOTH CONCERNS:

☐ 1. Bad bite?
☐ 2. Buck teeth/overjet?
☐ 3. Crowding of upper teeth?
☐ 4. Crossbite?
☐ 5. Grinding (Bruxism)?
☐ 6. Gummy smile?
☐ 7. Mouth too small?
☐ 8. Spaces?

RONCONE ORTHODONTICS

VI. HEALTH PROFESSIONAL(S): *(Current or have seen previously)*

(1) Doctor Name:

City, State:

Reason(s) for treatment:

(2) Doctor Name:

City, State:

Reason(s) for treatment:

(3) Doctor Name:

City, State:

Reason(s) for treatment:

COMMENTS:

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that is not reported above, I will inform the doctor at my next visit.

Patient/Responsible Party Print Name

Patient/Responsible Party Signature

Date

www.RonconeOrthodontics.com
221 Main Street, Suite 100 • Vista, CA 92084 • (760) 758-0630

RONCONE ORTHODONTICS