DESTEFANO
DENTISTRY

TMJ AND MUSCULOSKELETAL SCREENING QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Referred By: _____

Address: _____

_____

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by checking the appropriate boxes. (L = Left; R = Right; Y = Yes; N = No)

a. Pain in jaw joints ☐ L ☐ R

b. Pain in ear ☐ L ☐ R

c. Pain around the eyes ☐ L ☐ R

d. Pain in lower jaw ☐ L ☐ R

e. Pain in upper jaw ☐ L ☐ R

f. Pain in neck ☐ L ☐ R

g. Pain in shoulder ☐ L ☐ R

h. Pain in forehead ☐ L ☐ R

i. Pain in temples ☐ L ☐ R

j. Pain in facial muscles ☐ L ☐ R

k. Grating sound in joint ☐ L ☐ R

l. Subjective hearing loss ☐ L ☐ R

m. Clicking, snapping, or popping sound in joint (underline which sounds most descriptive)
If present, is it in ☐ L ☐ R

n. Dizziness (vertigo) ☐ Y ☐ N

o. Upset stomach-nausea ☐ Y ☐ N

p. Ringing sound in ears ☐ L ☐ R

q. Headaches ☐ L ☐ R

r. Fullness, pressure blockage in ear ☐ L ☐ R

s. Pain in tongue ☐ L ☐ R

t. Partial inability to open mouth ☐ L ☐ R
If yes, is it (1) Constant? ☐
(2) Sporadic? ☐

u. Difficulty chewing ☐ Y ☐ N

v. Difficulty swallowing ☐ Y ☐ N

w. Loud Snoring ☐ Y ☐ N

x. Constantly tired ☐ Y ☐ N

y. Mouth breath at night ☐ Y ☐ N

z. Awaken with a dry mouth ☐ Y ☐ N
If yes, is it (1) Frequently? ☐
(2) Rarely? ☐
(3) Never? ☐

1. What are your chief complaints? List from most to least important.

a. _____

b. _____

c. _____

Other symptoms (please write in).

_____

_____

2. Do symptoms affect one or both joints? ☐ Right ☐ Left ☐ Both

If both joints, indicate which joint seems most affected. ☐ L ☐ R

3. How many years, months, weeks or days have you been bothered by this problem?

a. _____ years b. _____ months c. _____ weeks d. _____ days

4. Have you ever had any injury to the jaw or face? ☐ Y ☐ N

5. Do you have arthritis? ☐ Y ☐ N

6. Have you ever had cervical traction? ☐ Y ☐ N

7. Have you ever worn a neck brace? ☐ Y ☐ N

8. Have you had any other treatment for this problem? ☐ Y ☐ N

(If yes, explain – medicine, exercise, dental appliances such as a splint, or night guard) _____

_____

9. Have you had your teeth straightened (orthodontia)? ☐ Y ☐ N

10. Have you had teeth removed for orthodontia? ☐ Y ☐ N

11. Have you ever had general anesthesia? ☐ Y ☐ N

12. Have you ever had your wisdom teeth removed? ☐ Y ☐ N

13. Did you have allergies as a child? ☐ Y ☐ N

14. Have you had your bite adjusted by your dentist (equilibration)? ☐ Y ☐ N

15. Do you attribute the symptoms to any one incident? ☐ Y ☐ N

(If yes, explain) _____

_____

16. Have you had Cortisone injected in a joint? ☐ Y ☐ N

If yes, when? _____ How many injects? _____

By whom? _____

17. Are you on any medications? ☐ Y ☐ N

If yes, what kind and how much? _____

_____

18. Do you know if you clench your teeth? ☐ Y ☐ N

19. Has anyone mentioned that you grind your teeth (brux) at night during sleep? ☐ Y ☐ N

20. Do you chew gum? ☐ Frequently ☐ Infrequently ☐ Moderately ☐ Never

21. Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on the back if necessary.

a. _____

b. _____

c. _____

d. _____

e. _____

22. Please write any other pertinent information that has not been covered previously. Write on the back of this sheet if necessary.

_____

_____

_____

23. Are you in litigation or are you planning litigation? ☐ Y ☐ N

If so, explain _____

_____

_____

_____

_____ _____

Parent's Signature Date