Holmes Dental Associates
General & Cosmetic Dentistry
TMJ Disorders

Bloomington 309.662.0523
Farmer City 309.928.2727
www.holmesdentalassociates.com

Welcome to Holmes Dental Associates !

On the following four pages is a questionnaire regarding your TMJ problem. Please answer these questions to the best of your ability as this will help us diagnose your condition.

Please bring with you to your initial appointment the following:

- The TMJ Questionnaire
- The Patient Information Form
- The Health History Form
- The HIPPA / Records Release Consent Form
- Any oral appliances, bite splints, or retainers that you have
- Any radiographs, MRI, or CT scans that are less than one year old.
- Any information about any previous treatment for your problem
- Referral form (if you were given one from a referring doctor)
- Dental insurance card
- Medical insurance card

You will find the forms, office location maps, contact information, and answers to most of your questions on our web site.

Please feel free to call us if you have any questions.

We look forward to meeting you !

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TMJ Problem Questionnaire

1. Name: ____ Birth date: ____/____/____

2. Today's date: ____/____/____

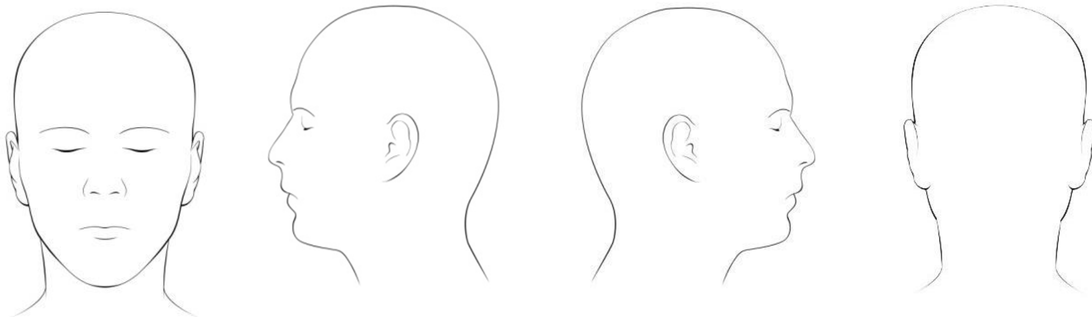
3. Where do you have pain? (Circle all that apply)

   Headache Neck Jaw Face Ear No Pain (If no pain, skip to question #11)

   Other: ____

4. Which side hurts? (Circle) Right Left Both

5. Place X's where your pain is located:



6. How long have you had this pain? ____

7. Describe your pain: (Circle all that apply)

   Constant Aching Burning Stabbing Throbbing Other: _________________

8. When is the pain the worst?: (Circle all that apply)

   Morning Afternoon Evening Night Time varies

9. What makes your pain better? ____

10. What makes your pain worse? ____

11. Have you ever sustained any trauma or whiplash to your head or neck? Yes No

If yes, describe: ____

____

12. Does it hurt to chew? Yes No

13. Does is hurt to open wide? Yes No

14. Do either of your jaw joints ***currently*** click, pop, or make other noises? Yes No

If yes, which one? Left Right

How long has this been happening? ______________________________________

15. Did either of your jaw joints ***used*** to pop or click but have ***stopped***? Yes No

If yes, which one? Left Right

When did it stop? ____

16. Has either of your jaw joints ever locked **open**? Yes No

If yes, which one? Left Right

If yes, when did this occur? ____

17. Has either of your jaw joints ever locked **closed**? Yes No

If yes, which one? Left Right

If yes, when did this occur? ____

18. Have you noticed any changes in the way your bite feels? Yes No

If yes, describe the change: ____

19. Have you noticed any crookedness or asymmetry in your jaw or face? Yes No

If yes, describe the change: ____

20. Do you think you have a habit of clenching your teeth? Yes No

21. Do you think you have a habit of grinding your teeth? Yes No

22. Do you have any pain or difficulty swallowing? Yes No

23. Do you have any problems with your ears, such as pain or ringing ? Yes No

If yes, describe the problem: ____

____

24. How would you rate your pain when it is the **worst**? (Zero is no pain, ten is severe.)

Circle: 0 1 2 3 4 5 6 7 8 9 10

How often or what percentage of the time is the pain this bad? ___________________

25. How would you rate your pain when it is the **least**? (Zero is no pain, ten is severe.)

Circle: 0 1 2 3 4 5 6 7 8 9 10

26. Have you had any prior treatment for your TMJ problem? Yes No

If yes, please answer the following:

Daytime bite splint? Yes No When? ______________________________

Did it help? Yes No

Nighttime bite splint Yes No When? ______________________________

Did it help? Yes No

Bite adjustment? Yes No When? ______________________________

Did it help? Yes No

Orthodontics? Yes No When? ______________________________

Did it help? Yes No

Chiropractic? Yes No When? ______________________________

Did it help? Yes No

Physical Therapy? Yes No When? ______________________________

Did it help? Yes No

Surgery? Yes No When? ______________________________

Did it help? Yes No

Medications? Yes No When? ______________________________

Did it help? Yes No

Name the drug(s): ____

____

27. Do you currently snore? Yes No

28. Do you wear a CPAP device for sleep apnea? Yes No

Please summarize your TMJ problem and treatment goals: ______________________________

____

____

____

____

____

List the doctors to whom reports may be sent if they request them or if we deem it necessary:

Your dentist (if not Holmes Dental): ____

Your physician: ____

Other(s): ____

____

I have completed the above questions to the best of my knowledge. I consent to the use of my records for scientific publication or teaching provided my name remains anonymous.

____ ________/_________/__________

Signature Date

(If patient is a minor, parent / guardian signature)