ARCH
DENTAL

# TMJ Patient Questionnaire

Patient Name: _____
Date: _____

**YES NO**

____ ____ 1 ) Do you have frequent or regular headaches?
____ Upon awakening
____ Late afternoon

____ ____ 2 ) Are your jaw muscles sore or tender?

____ ____ 3 ) Are your joints sore or tender when you eat or chew?

____ ____ 4 ) Have you ever received an injury to your jaw or face?
If yes, describe:
_____
_____
_____

____ ____ 5 ) Do your joints make any noise such as snapping, clicking, or popping?

____ ____ 6 ) Do your joints lock when you are trying to open or close?

____ ____ 7 ) Do you have any teeth that are sensitive, sore, aching, or uncomfortable?

____ ____ 8 ) Have you ever worn a splint or night guard?
If yes: How many? _____

____ ____ 9 ) Are you taking or have you taken any medication for these symptoms?

____ ____ 10 ) Have you ever seen a dentist or a TMJ specialist for treatment of any of above symptoms?
If yes: How many? _____

321 4th Street, North Fargo, ND 58102 P: 701.235.6075 F: 701.239.0140
W: archdentalfargo.com E: info@archdentalfargo.com