

Knoxville Oral & Maxillofacial Surgery, PC

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TMJ AND FACIAL PAIN QUESTIONNAIRE

1. Name _____

2. Address _____

3. Age _____ 4. Referred by _____

5. Describe your problem: _____

6. How long has this pain been present? _____

7. Does the problem limit your ability to open, close, or chew? _____

If so, how? _____

8. Was there any event which you believe may have caused this problem?

If so, please describe:

Accident/Injury: _____ Dental Treatment: _____

Surgery: _____ Stress: _____

Other: _____

9. What other health care specialists have you seen regarding this problem?

10. Describe any treatments you have had.

Medicines: _____

Physical Therapy: _____

Teeth Adjustments: _____

Bite Splints: _____

Orthodontics: _____

Surgery: _____

Stress Management: _____

Other: _____

11. Which side hurts? ___ Right ___ Left ___ Both ___ Neither

12. Is the pain CONSTANT or OCCASIONAL? (circle one)

13. When is the pain worse? Morning Afternoon Evening (circle one)

14. Does anything you do make the pain worse? _____

What? _____

15. Does anything you do make the pain better? _____

What? _____

16. Does it hurt to move your jaw? _____

to chew? _____

to open wide? _____

to move side to side? _____

17. Do you have or have you had any of the following?

- | | |
|------------------------|---------------------------|
| ___ Sinus Problems | ___ Headaches |
| ___ Migraine Headaches | ___ Depression |
| ___ Stressful Job | ___ Neck Ache |
| ___ Sensitive Teeth | ___ Trouble Sleeping |
| ___ Arthritis | ___ Home Stress |
| ___ Back Pain | ___ Ear Ache |
| ___ Ringing in Ears | ___ Dizziness |
| ___ Hearing Changes | ___ Irritable Bowel |
| ___ Gum Disease | ___ Nervous Stomach |
| ___ Allergies | ___ Ulcers |
| To what? _____ | ___ Mitral Valve Prolapse |

List other medical problems _____

18. Does your jaw joint make noise now? Yes No Has it in the past? Yes No
___ click ___ pop ___ grind ___ Other _____

When? _____ For how long? _____

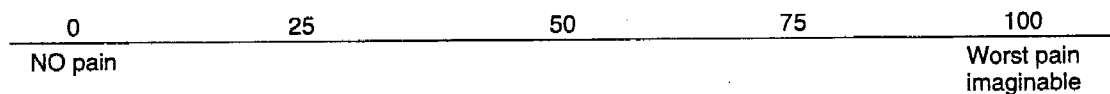
19. Does your jaw ever lock open? _____ lock closed? _____

How has it been treated? _____

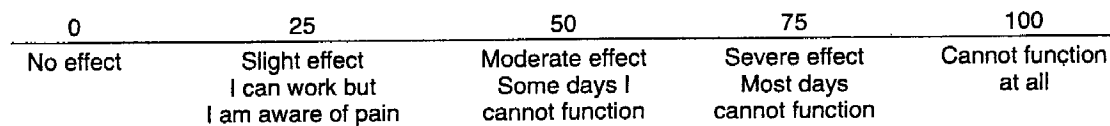
Can you do anything to prevent or treat this? _____

20. Do you grind or clench your teeth? _____

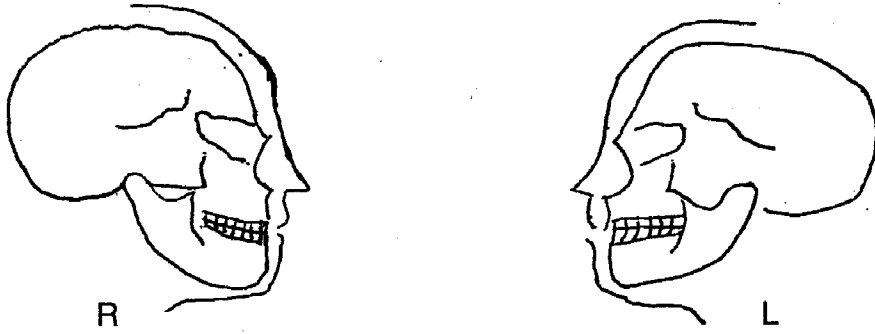
21. On the scale below mark where your pain falls:



22. The pain is having this affect on my life.



23. Draw an outline and shade the area of your pain.



24. Circle from the list below those words which best describe your pain.

- | | | | | | |
|------------|-------------|-----------|----------|----------|--------------|
| pulsing | jumping | pricking | sharp | pinching | tugging |
| burning | throbbing | flashing | boring | cutting | cramping |
| wrenching | scalding | pounding | shooting | stabbing | lacerating |
| crushing | searing | tingling | dull | tender | tiring |
| sickening | fearful | punishing | smarting | aching | taut |
| exhausting | suffocating | frightful | cruel | stinging | heavy |
| splitting | terrifying | killing | wretched | mild | annoying |
| blinding | distressful | miserable | horrible | intense | excruciating |
| unbearable | | | | | |

25. Are there any additional comments you would like to make? _____
