TMJ SCREENING HISTORY

Patient : last name : _____ first name : _____ mid name : _____

1. Have you ever had a problem with your jaw joints (your TMJs)? Yes No
2. Have you ever been injured by a blow to the jaw? Yes No
3. Do your jaw joints ever hurt or become tender when you chew or talk? Yes No
4. Do you notice any tenderness when you open wide? Yes No
5. Do you ever have any clicks, pops, or grating sounds in your jaw joints? Yes No
6. Did you ever have any clicks or pops? Yes No
7. Do you have frequent headaches? Yes No
   If so, how often? _____
   When? _____
8. Has your jaw ever locked open? Yes No
   Has your jaw ever locked closed? Yes No
9. Do you ever have difficulty opening? Yes No
10. Have you ever been treated for a TMJ problem?
    - ☐ Bite Splint
    - ☐ Medication
    - ☐ Surgery
    - ☐ Orthodontics
    - ☐ Physical Therapy
    - ☐ Equilibration
    - ☐ Counseling

DOCTOR'S COMMENTS