TMJ HEALTH QUESTIONNAIRE

NAME _____ Date _____

CHIEF COMPLAINT _____

DATE OF ONSET _____

PAIN SYMPTOMS

Do you get headaches? Y N
Do you get migraine headaches? Y N
Do you frequently have neck aches or stiff neck muscles? Y N
Have you ever had chronic shoulder or back pain? Y N
Do you have trouble sleeping soundly? Y N
Are your jaws tired when you awaken? Y N
Are your teeth sore when you awaken Y N

Are your wisdom teeth extracted? Y N

What medication(s), if any, are you taking?

_____

_____

Do you get headaches in right or left temple areas? Y N
Do you get headaches in the front or back of your head? Y N

Do you clench your teeth during the day? Y N
Do you clench your teeth during the night? Y N
Do you grind your teeth when asleep? Y N

When are your symptoms worse?

_____

Does anything make you feel better?

_____

_____

How often do you take medication for relief of pain?

_____

TRAUMA OR ACCIDENTS

Have you ever had a severe blow to the head or jaw? Y N
Any whiplash neck injuries? Y N

Have you ever been involved in any serious accidents, such as a car accident? Y N
Details _____

_____

JAW JOINT SYMPTOMS

Does your jaw feel tired after a big meal? Y N
Are there any foods you avoid eating? Y N
Do you ever get dizzy? Y N
Do you ever feel faint? Y N
Do you ever feel nauseated (sick)? Y N
Is there a family history of jaw joint (TMJ) problems or headaches? Y N

Do you feel or hear a 'clicking', 'popping' or 'cracking' noise from either jaw joint? Y N
Has your jaw ever locked when you were unable to open or close? Y N
Do you have difficulty opening wide or yawning? Y N
Have you ever had pain in either jaw joint? Y N
Does your jaw ache when you open wide? Y N

EAR AND EYE SYMPTOMS

Do you have any pain in your ears? Y N
Do you suffer from any loss of hearing? Y N
Do you have itchiness or stuffiness in either ear? Y N
Do you hear ringing, buzzing or hissing sounds in either ear? Y N

Do you wear glasses or contacts? Y N
Are there times when your eyesight blurs? Y N
Do you get pain in, around or behind either eye? Y N

BREATHING

Do you have allergies? Y N
Do you have sinus problems? Y N
Do you have snore at night? Y N

Is your nose stuffed when you don't have a cold? Y N
Have you been diagnosed with Sleep Apnea? Y N
Have you had a sleep study done at a Sleep Clinic (hospital)? Y N

SIGNATURE _____

Patient Name (PRINT) _____

Section 1: Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:
(0=never, 1=slight, 2=moderate, 3=high chance of dozing) – CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading……	0	1	2	3
Watching television……	0	1	2	3
Sitting in a public place…….	0	1	2	3
As a passenger in a car for one hour…….	0	1	2	3
Driving a car stopped for a few minutes in traffic……..	0	1	2	3
Sitting & talking to someone……	0	1	2	3
Sitting down quietly after lunch without alcohol……	0	1	2	3
Lying down to rest in the afternoon……	0	1	2	3

Total Score: _____

Section 2: Patient Evaluation

Fill in the blanks, circle one yes or no response for each question

		No(0)	Yes(1)
BMI (See Attached Chart):	_____ Is it greater than or equal to 30?	0	1
Neck Circumference	_____ Is it >17" (Men) or >15"(Women)?	0	1
Have you gained at least 15lbs in the past 6 months?		0	1

Total Score: _____

Section 3: Subjective Sleep Evaluation

Please circle one yes or no response for each question

	No(0)	Yes(1)
Do you snore?.....	0	1
You, or your spouse, would consider your snoring louder than a person talking….	0	1
Your snoring occurs almost every night……..	0	1
Your snoring is bothersome to your bed partner……..	0	1
Do you feel that in some way your sleep is not refreshing or restful?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day and have difficulty staying awake?.....	0	1
Do you have trouble remembering things or paying attention during the day?.....	0	1
Do you have high blood pressure?.....	0	1

Total Score: _____

Section 4: Prior Diagnosis

	No(0)	Yes(1)
Have you previously been diagnosed with sleep apnea?	0	1

If Yes:

When were you diagnosed? (Approx mo/yr) _____
Were you put on CPAP Therapy for treatment? _____
Are you still using your CPAP every night? _____

Total Score: _____

Notes: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of page if necessary.)

Patient Signature:_____ Date: ____/____/_____

OFFICE USE ONLY

Advanced screening criteria, if yes to any below pt should be scheduled for advanced OSA screening.
_____ ESS Score ≥ 8? _____ Pt. Eval ≥ 2? _____ Subjective Sleep Eval ≥ 3? _____ Prior OSA Diagnosis ≥ 1?