



**GREGORY ABATE DDS**

*Aesthetic and Preventive Dentistry*

## TMJ Patient Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Answer all that apply.

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 nightguard?**

If yes: How many? \_\_\_\_\_

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**9) Are you taking or have you taken any medication for these symptoms? If yes: Describe:**

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**10) Have you ever seen a dentist or a TMJ specialist for treatment of any of the above symptoms? If yes: How many? \_\_\_\_\_**