In your own words, please describe the reason you are concerned about your jaw joints.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please describe your stress level: _____________________________________________

Please indicate if you are experiencing any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial Pain</td>
<td>YES</td>
<td>NO</td>
<td>If so, indicate where on diagram.</td>
</tr>
<tr>
<td>Jaw pain</td>
<td>YES</td>
<td>NO</td>
<td>If so, indicate where on diagram.</td>
</tr>
<tr>
<td>Neckaches</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Jaw soreness on waking</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Headaches on waking</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Eye Pain</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Ear Pain</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Pain While Eating</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

If you answered yes to any of the questions above, please describe what type of discomfort you are experiencing, as well as the location and duration.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Temporomandibular Joint Questionnaire

Name: ____________________________

Are you currently experiencing any of the following:

- Dizziness  YES  NO
- Lightheadedness  YES  NO
- Visual Disturbances  YES  NO
- Post Nasal Drainage  YES  NO
- Difficulty Swallowing  YES  NO
- Chronic Sore Throat  YES  NO
- Difficulty Opening Mouth  YES  NO
- Difficulty Closing Mouth  YES  NO
- Clicking of Jaw  YES  NO
- Ring/Buzz in Ears  YES  NO
- Facial Muscle Spasms  YES  NO
- Fractured Teeth  YES  NO
- Difficulty With Speech  YES  NO

Please comment as necessary.

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Have you been involved in a motor vehicle accident or sustained an injury to your jaw?

YES  NO

If so, please give a date and a brief description of the accident/injury.

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Temporomandibular Joint Questionnaire

Have you ever been treated for jaw joint problems?

YES       NO

If so, please give dates, description, and names of providers to the best of your recollection.

---

To be completed by Dr. Widner.

ROM: Pain free opening  _____ mm  Passive stretch opening  _____ mm
     Maximum opening  _____ mm  Maximum protrusion  _____ mm
     Lateral - right  _____ mm  Lateral - left  _____ mm
     Deviation on opening:  

Masticatory Muscle Exam (0=none, 1=slight, 2=moderate, 3=severe):

TMJ Lateral Capsule
  RIGHT  _____  LEFT  _____
Masserter
  _____
Temporals
  _____
Medial Pterygoid
  _____
Lateral Pterygoid
  _____
Sternocleidomastoid
  _____
Posterior Cervical
  _____

Auscultation (0,1,2,3):
  RIGHT  _____  LEFT  _____
Clicking/Popping
  _____
Crepitus
  _____
With Opening
  _____ mm  _____ mm
With Closing
  _____ mm  _____ mm

Occlusion:  Class ___, Division ___  Vert. Overlap ____ mm  Hor. Overlap ____ mm

Open Bite:  Anterior  Posterior
Crossbite:  Anterior  Posterior
Occlusal Wear:  Slight  Moderate  Severe
Tooth Mobility:  Slight  Moderate  Severe
Bruxism:  Clenching  Night  Day  Patient aware  Denies