Centreville Dental Wellness Center, PC

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Temporomandibular Joint (TMJ) Dysfunction Questionnaire

2. Do you have sensations or stuffiness, pressure or blockage, ringing, hissing or buzzing in your ears? Yes No No No No No No No N	Patier	nt Name:I	Date:		
3. Do you ever feel dizzy or faint? Yes No 4. Is your jaw painful or locked when you wake up in the morning? Yes No 5. Do you consider yourself chronically fatigued? Yes No 6. Are you ever nauscated for no apparent reason? Yes No 7. Do your fingers sometimes go numb? Yes No 8. Check any area where you have pain or soreness: Jaw joints Upper jaw or teeth Back of head Forehead Lower jaw or teeth Yes No 9. Is it hard to move your jaw side-to-side, forward or backward? Yes No 10. Do have difficulty chewing? Yes No 11. Do have back teeth missing? Yes No 12. Have you had extensive dental crowns and bridge work? Yes No 13. Do you clench your teeth during the day? Yes No 14. Do you grind your teeth at night? (Ask someone else) Yes No 15. Do you ever have a headache when you wake up? Yes No 16. Have you had a whiplash injury? Yes No 17. Have you worn a cervical collar or had neck traction? Yes No 18. Have you ever had a blow to the chin, face, or head? Yes No 19. Have you reach the point at which drugs no longer relieve your symptoms? Yes No 20. Does chewing gum start your symptoms? Yes No 21. Does your jaw deviate to the left or right when you open wide? Yes No 22. When your mouth is wide open, can you insert three fingers into your mouth vertically? Yes No	1. I	Do you have a grating, clicking, or popping sound in either or both jaws when you chew?		□Yes	□No
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23. Please write a brief narrative of your past medical and dental history (including injuries) pertaining to the jaw joint:	22. V	When your mouth is wide open, can you insert three fingers into your mouth vertically?	☐ Yes	□ No	
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