

◀Stephen M. Cambre, DDS▶

Name: _____

Date: _____

SCREENING QUESTIONNAIRE FOR TMD

YES NO

- ___ ___ 1) Do you have difficulty, pain or both when opening your mouth, for Instance when yawning?
- ___ ___ 2) Does your jaw “get stuck”, “lock” or “go out”?
- ___ ___ 3) Do you have difficulty, pain or both when chewing, talking or using your jaws?
- ___ ___ 4) Are you aware of noises in the jaw joints?
- ___ ___ 5) Do your jaws regularly feel stiff, tight or tired?
- ___ ___ 6) Do you have pain in or about the ears, temples or cheeks?
- ___ ___ 7) Do you have frequent headaches, neck aches or toothaches?
- ___ ___ 8) Have you had a recent injury to your head, neck or jaw?
- ___ ___ 9) Have you been aware of any recent changes in your bite?
- ___ ___ 10) Have you been previously treated for unexplained facial pain or a jaw joint problem?

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