COLORADO SPRINGS
ORAL & FACIAL SURGERY

Patient Name_____
Date_____

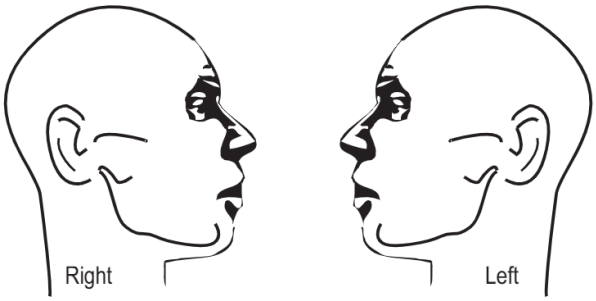
Facial/TMJ Pain Questionnaire

CHIEF COMPLAINT

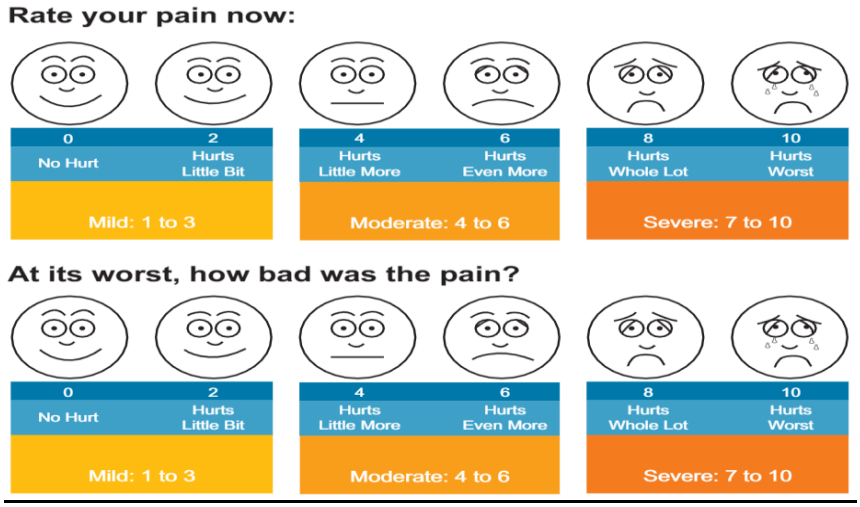
- What is the main problem that brings you here? _____
  _____
- Did this problem begin: **SUDDENLY** **GRADUALLY**
- How long have you been bothered by this problem? **YEARS** **MONTHS** **WEEKS** **DAYS**

PAIN SYMPTOMS

- Location: (please circle or indicate where you are having pain)



- Headaches (answer only if you have regular heachaches)
  - How often? _____
  - Time of Day _____
  - Location: **ONE SIDE** **BOTH SIDES**
  - Previous Diagnosis and Treatment
- Circle all the terms that describe your pain:
  SHARP **DULL** **ACHING** **DEEP** **SUPERFICIAL** **BURNING** **PULSING** **SPREADING**
- Rate your pain today by placing a ling on the scale:



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DYSFUNCTION

- Can you open your mouth: **NORMALLY PARTIALLY VERY LIMITED**
- Has your jaw ever locked **open** or **shut**: **YES NO**
    - Did you require the aid a healthcare professional to resolve the lock? **YES NO**
- Do you have any of these sounds in your jaw joints?

    CLICKING/POPPING: R L GRINDING: R L

- If you have any of these problems, is it: **FREQUENTLY OCCASIONALLY CONSTANTLY**
- Have you noticed any change in your bite or ability to chew: **YES NO**
- Have you had to make any dietary changes? **NO CHEW DIET SOFT DIET REGULAR DIET**

OTHER QUESTIONS AND COMPLAINTS

- Are your jaws clenched or teeth sore when you awaken from sleep? **YES NO**
- Do you grind or clench your teeth during the **DAY** or **NIGHT**? **YES NO**
- Do you chew gum or ice? **YES NO**
- Are your muscles ever tired? **YES NO**
- Have you had braces? **YES NO**
- Have you ever had your bite adjusted by your dentist? **YES NO**
- Do you play a musical instrument or sing? **YES NO**

Please list any other pertinent information you feel we should know: _____

_____

_____

Have you been treated previously for this problem? _____
By Whom: _____ Telephone number: _____

Diagnosis and Treatment: _____
_____