JOHN M. KOROLEWSKI, D.D.S.

TMJ Questionnaire

To assist us in diagnosing your condition, please print out and complete the following questionnaire. Bring it with you to your visit.

In your own words, describe your symptoms_____

_____

_____

List any other health professional you have seen for these symptoms

_____

_General Dentist's Name _____

Date of last dental appointment_____

Treatment / purpose of appointment _____

Do you have any problems with your jaw or jaw joint(s)? YES / NO

Describe _____

_____

Have you received treatment for your jaw problems? YES / NO

Who directed this treatment? _____

What was the treatment?	Yes No	Success of treatment (1=good / 2=fair / 3=poor)
Bite Splint	_____	_____
Medication	_____	_____
Physical therapy	_____	_____
Occlusal adjustment	_____	_____
Orthodontics	_____	_____
Counseling	_____	_____
Surgery	_____	_____
Other	_____	_____

Do you do anything to relieve the pain?_____

Are you aware of anything that makes the pain worse?_____

Is it painful to open your jaw wide? YES / NO Painful to chewing in your jaw? YES / NO

Do your jaw joints make noises? YES / NO

RIGHT Clicking____ Popping____ Grinding____

LEFT Clicking____ Popping____ Grinding____

Has your jaw ever locked open? YES / NO Last time?_____

Has your jaw ever locked closed? YES / NO Last time?_____

Have you ever injured your jaws? YES / NO

When?_____Please describe the injury_____

_____

Do you have headaches? YES / NO How often?_____

Do you wake with headaches? YES / NO Do you grind/clench your teeth? YES / NO

Do you consider yourself to be under more stress than most people? YES / NO

Please provide any additional information you fee may be helpful it the diagnosis or treatment of your condition._____

_____

_____

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