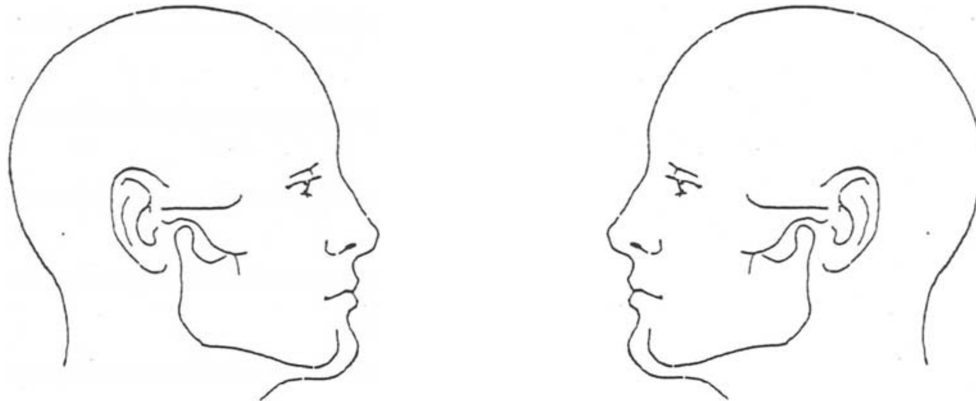
RANDOLPH L. LAIS, DDS, PA
comprehensive fine dentistry
5508 Pinnacle Point Drive, Suite A, Rogers, Arkansas 72758

FACIAL PAIN (TMJ) QUESTIONNAIRE

1. Name ______________________________ Age ________ Date ________________
2. Describe your symptoms ____
3. Which side hurts? Right __________ Left __________ Both __________
4. For how long? ____
5. Is the pain constant or intermittent? _____________________________________
6. Is the pain worse in morning, afternoon, or evening? ________________________
7. Does it hurt to move your jaw? __________ To chew? __________
8. On the figures below please outline where your pain is.



9. Does your jaw make noise? __________
   Clicking? __________ Grinding? __________ Other? ________________________
   If yes, when? _______________________ For how long? _____________________
10. If your jaw does not make noise now, has it ever in the past? __________
    Describe: ____
11. Has your jaw ever locked open? __________ Closed? __________
    Describe: ____
12. Do you have any of the following?
    a. Headaches __________
    b. Neck Aches __________
    c. Shoulder Pain __________
    d. Ear Pain __________
    e. Ringing in the ears __________
    f. Dizziness __________
    g. Change in hearing __________

FACIAL PAIN (TMJ) QUESTIONNAIRE (continued)

13. Do you grind or clench your teeth? ___________
14. Do you have sore or sensitive teeth? ___________
15. Do you have trouble getting to sleep? ___________ Do you sleep well? ___________
    Describe: ____
16. Do you consider yourself to be under a lot of stress? ___________
17. Have you ever had a nervous stomach, ulcers, or skin disease? ___________
18. Do you have or have you ever had arthritis? ___________
19. Does your pain keep you from doing anything? ___________
    If yes, what? ____
    ____
20. Can you remember any injury to your jaw? ___________
    If yes, describe: ____
    ____
21. Do you take medications for the pain? ___________
    If yes, what? ____
    ____
22. Do you take medications for relaxation? ___________
    If yes, what? ____
    ____
23. Have you had treatment for your symptoms? ___________
    If yes, what kind? ____
    a. Bite Splint ___________
    b. Medication ___________
    c. Physical Therapy ___________
    d. Counseling ___________
    e. Occlusal Adjustment ___________
    f. Orthodontics ___________
    g. Surgery ___________
    h. Other ____
    ____

____ _______________________

Patient Signature Date