DARREN G. KOCH, D.D.S., P.A.
FAMILY AND COSMETIC DENTISTRY

TMJ PATIENT QUESTIONNAIRE:

Patient Name: _____ Date: ___ / ___ / ___

1. Do you have frequent or regular headaches? If YES, When? In the morning **OR** Late afternoon	YES	NO
2. Do you have sore or tender jaw muscles?	YES	NO
3. Do you have sore or tender joints when you chew?	YES	NO
4. Have you ever suffered an injury to the jaw or face? If YES, please describe: _____	YES	NO
5. Do your joints make any noise such as clicking or popping?	YES	NO
6. Do your joints lock when you try to open or close?	YES	NO
7. Do you have any teeth that are sore, sensitive, or uncomfortable?	YES	NO
8. Do you currently wear a nightguard? If YES, is it: Over-the-Counter **OR** Custom Made by a Dentist	YES	NO
9. Are you taking any medications for these symptoms? If YES, please describe: _____	YES	NO
10. Have you ever been treated by a dentist or TMJ specialist for any of the above symptoms?	YES	NO

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