DR. TERRY D. OLEJKO
ORAL AND MAXILLOFACIAL SURGERY

TMJ EVALUATION RECORD

NAME____

REFERRED BY DOCTOR____

ABOUT YOUR JAW PROBLEM

1. Do you have jaw joint pain?
   ( ) No ( ) Yes ( ) Right ( ) Left

2. Do you have ear pain?
   ( ) No ( ) Yes ( ) Right ( ) Left

3. Do you have pain in the jaw, face, or neck?
   ( ) No ( ) Yes ( ) Right ( ) Left

4. Are you aware of your jaw making noises?
   ( ) No ( ) During chewing ( ) Right ( ) Left
   ( ) During Extreme opening ( ) Right ( ) Left

5. Do you have any other joint problems?
   ( ) No ( ) Yes, If yes what joints___________________________________

6. Do you have pain when you chew?
   ( ) No ( ) Yes ( ) Right ( ) Left

7. Do you have pain when you open wide or take a big bite?
   ( ) No ( ) Yes ( ) Right ( ) Left

8. Do you have pain when you speak?
   ( ) No ( ) Yes ( ) Right ( ) Left

9. Does the pain or discomfort interfere with your work or other activities?
   ( ) No ( ) Yes ( ) Occasionally

10. Are certain foods difficult to chew
    ( ) No ( ) Yes ( ) Thick sandwiches ( ) Hard, tough ( ) Lettuce

11. Do you prefer to chew on one side?
    ( ) No ( ) Yes ( ) Right ( ) Left

12. How long has this problem bothered you?________________________________

13. Must you take medication for the pain or discomfort?
    ( ) No ( ) Yes ( ) Occasionally

14. Have you ever been in an accident or received a blow to the face?
    ( ) No ( ) Yes Describe injury____________________________________

    ____

15. Have you ever had your teeth ground on to make them fit together better?
( ) No ( ) Yes Year______________

16. Are you aware of clenching or grinding your teeth?
( ) No ( ) In sleep ( ) In tension

17. Has your jaw ever locked?
( ) No ( ) Open ( ) Closed

18. Have you had surgery requiring general anesthesia?
( ) No ( ) Yes Specify____

19. Do you have any of the following habits?

( ) Pencil biter	( ) Pipe stem biter	( ) Play musical instrument	( ) No
( ) Fingernail biter	( ) Gum chewer	( ) Telephone/shoulder position	
( ) Cheek biter	( ) Hand/jaw position	( ) Wide open mouth procedure	

20. Do you have headaches?

( ) Occasional	( ) Yes	( ) Frontal	( ) None
( ) Regular	( ) Left	( ) Temporal	
( ) Severe	( ) Both	( ) Back/neck	

21. On a scale of 0 - 5, where 0 represents no pain and 5 represents extreme pain, indicate your level:___________

22. Have you had any dental work recently?
( ) No ( ) Yes (extractions, orthodontics, fillings, crowns, dentures)

23. Do you feel nervous? Are you under emotional tension?
( ) No ( ) Questionable ( ) Probable ( ) Definite

24. Does this problem bother you more?

( ) In the morning	( ) Evening	( ) No specific time
( ) Mid afternoon	( ) While trying to sleep	( ) All of the time

25. Does this problem alter your life style?
( ) No ( ) Yes

26. Have you had weight loss?
( ) No ( ) Yes How much________________

27. Does your TMJ problem create emotional stress?
( ) No ( ) Yes

28. Are you taking any medication?
( ) No ( ) Yes Specify____

29. Have you had any other medical problems requiring treatment?
( ) No ( ) Yes Specify____