THE OHIO STATE UNIVERSITY

College of Dentistry

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Division of
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Dear New Patient,

Welcome to the Oral and Maxillofacial Surgery Faculty Practice at the Ohio State University Medical Center! We are pleased that you have chosen to seek care for your temporomandibular joint (TMJ) disorder with us and we look forward to meeting you in person.

Because TMJ disorders are often complex, it is important that we gather detailed information from you in order to best diagnose and treat your problem. To help with this, we are enclosing a set of forms for you to fill out. Please take the time to complete them *before* you arrive for your appointment. We understand that the forms are lengthy, but they are designed to gather information that has been shown through scientific research to be relevant to many TMJ problems. The medical information you provide will be reviewed at your appointment and will be very helpful to us as we work to help you.

We sometimes do research using pools of information we gather from patients. However, you must generally give us written permission before your identity and health information can be shared with anyone, as required by all laws and practices regarding protected health information and research. The enclosed forms collect information we need even if you do not participate, so please complete them even if you are sure you will not take part in any research. If you would like further information about any studies in which your information might be included, please ask during your appointment. There is no obligation to participate, and whatever you decide will not change the care you receive from us.

As always, please remember to bring your medical and dental insurance cards and information with you so we can file benefit claims on your behalf. If you have TMJ x-rays, CT or MRI reports or (better still) CDs with images, please bring them as well. We look forward to welcoming you to Postle Hall, home of the College of Dentistry and our practice.

Sincerely,

Gregory M. Ness, DDS
D.P. Snyder Professor of Oral Surgery
Residency Program Director

We appreciate the time you spend completing this questionnaire. The information you provide is confidential and will allow us to provide you the best care possible. Thank you. Sincerely, Clinic Staff

5. Please list all major HOSPITALIZATIONS OR SURGERIES for any surgical operation or illness in the past.

Date	Reason or Procedure	Name and Address of Hospital

6. Please list any MAJOR ILLNESSES OR SPECIAL MEDICAL OR PSYCHOLOGICAL PROBLEMS that you have now or have had in the past.

Date	Reason	Name and Address of Doctor Who Treated You

7. What MEDICATIONS are you CURRENTLY taking for any health problems?

Medication Name	Dossage Per Day (mg, cc, etc.)	Times Per Day	Reason	Length of Time Taken

8. What MEDICATIONS have you taken for the problem IN THE PAST but not now?

Medication Name	Dossage Per Day (mg,cc,etc)	Times Per Day	Reason	When and why Did You Stop?

HEALTH PROBLEMS: Please check all health problems that you currently have or had in the past.

9. Cardiovascular	Yes	No
Rheumatic fever/heart disease	☐	☐
Heart murmur	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Infective endocarditis	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Angina	☐	☐
Heart attack	☐	☐
Congenital heart defect or lesion	☐	☐
Heart surgery/angioplasty	☐	☐
Pacemaker/defibrillator	☐	☐
Stroke	☐	☐
Vascular disease or surgery	☐	☐
Aneurysm	☐	☐
Other heart problems	☐	☐

10. Respiratory	Yes	No
Asthma	☐	☐
Bronchitis/Pneumonia	☐	☐
Emphysema	☐	☐

11. Allergic/Immunologic	Yes	No
Hay fever	☐	☐
Anaphylactic shock reaction	☐	☐
Reaction to foods:	☐	☐
Type of food: ______________________		
Reaction to local anesthetic (novacaine)	☐	☐
Reaction to penicillin, other antibiotics	☐	☐
Reaction to sulfa drugs	☐	☐
Reaction to sedatives, or sleeping pills	☐	☐
Reaction to barbiturates	☐	☐
Reaction to aspirin or other pain medication	☐	☐
Reaction to iodine	☐	☐
Reaction to other medications	☐	☐
List:		

12. Gastrointestinal	Yes	No
Stomach/intestinal ulcers	☐	☐
Gastritis	☐	☐
Colitis	☐	☐
Liver disease/jaundice	☐	☐
Gall Bladder Stones	☐	☐

13. Oropharyngeal Disorders	Yes	No
Stomach reflux-heartburn	☐	☐
Bad breath (malodor)	☐	☐
Enlarged tonsils	☐	☐

14. Eyes	Yes	No
Glaucoma	☐	☐
Full or Partial Blindness	☐	☐
Wear glasses/contacts	☐	☐

15. Ear and Nose, and Throat	Yes	No
Sinusitis or sinus headache	☐	☐
Nasal rhinitis	☐	☐
Inner ear infections	☐	☐

16. Neurologic	Yes	No
Multiple sclerosis (MS)	☐	☐
Epilepsy, seizures or convulsions	☐	☐
Migraine	☐	☐
Muscular dystrophy	☐	☐
Cerebral Palsy	☐	☐
Parkinon's Disease	☐	☐

17. Infectious disease	Yes	No
Sexually transmitted disease(syphilis, gonorrhea, or genital herpes)	☐	☐
HIV positive	☐	☐
Hepatitis Type:____________________________.	☐	☐
Tuberculosis (TB)	☐	☐
Other current infectious disease	☐	☐

18. Skin/Integumentary	Yes	No
Allergy to latex (rubber)	☐	☐
Hives or allergic skin rash	☐	☐
Psoriasis (chronic skin rash)	☐	☐
Dark moles (recent change in appearance)	☐	☐
Birth marks	☐	☐

19. Endocrine	Yes	No
Diabetes	☐	☐
Thyroid disease	☐	☐
Pancreatic disease	☐	☐

20. Genito-Urinary	Yes	No
Bladder problem/ infections	☐	☐
Kidney disease	☐	☐
Women	**Yes**	**No**
Are you taking contraceptives	☐	☐
Are you pregnant	☐	☐
Are you nursing presently	☐	☐
Had a miscarriage or stillbirth	☐	☐
Had a hysterectomy or ovariectomy	☐	☐
Are you on hormone replacement therapy	☐	☐
Dysmenorrhea (painful menstrual periods)	☐	☐
Premenstrual syndrome (PMS)	☐	☐
Menopause	☐	☐
Breast cancer	☐	☐
Men	**Yes**	**No**
Testicular tumors or disorders	☐	☐
Prostatitis	☐	☐
Prostate cancer	☐	☐
Breast cancer	☐	☐

21. Hematologic/Lymphatics	Yes	No
Blood transfusion	☐	☐
Anemia	☐	☐
Hemophilia/other bleeding disorders	☐	☐
Leukemia	☐	☐
Sickle Cell Anemia Disease	☐	☐
Tumor or cancer	☐	☐
Chemotherapy	☐	☐
Radiation therapy	☐	☐

22. Musculoskeletal/Rheumatic	Yes	No
Fibromyalgia	☐	☐
Chronic fatigue syndrome	☐	☐
Osteoarthritis	☐	☐
Osteopoerosis	☐	☐
Rheumatoid arthritis	☐	☐
Artificial joint (knee/hip/other)	☐	☐
Sjogren's syndrome	☐	☐
Muscle pain/rheumatism	☐	☐

23. Mental Health	Yes	No
Depression	☐	☐
Anxiety disorder	☐	☐
Mental health treatment	☐	☐
Physical or sexual abuse	☐	☐
Eating disorder	☐	☐

COMMENTS:

REVIEW OF SYSTEMS: Please check all symptoms that you have had recently (in the past month).

24. Constitutional Symptoms	Yes	No
Frequent fever	☐	☐
Weight loss or gain recently	☐	☐
Unsteady when walking/standing	☐	☐
General weakness	☐	☐
Fatigue	☐	☐
Chills	☐	☐
Hot and cold spells	☐	☐
Change in appetite	☐	☐

25. Cardiovascular	Yes	No
Racing heart (palpitations)	☐	☐
Chest pain	☐	☐
Cold hands	☐	☐
Swollen feet/ankles	☐	☐

26. Respiratory	Yes	No
Chronic cough	☐	☐
Cough up blood	☐	☐
Shortness of breath	☐	☐
Breathing difficulties	☐	☐

27. Gastrointestinal	Yes	No
Stomach pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Persistent diarrhea	☐	☐
Persistent constipation	☐	☐
Heartburn /indigestion	☐	☐
Bloody or black stools	☐	☐
Pain with bowel movement	☐	☐
Bloating (gassy feeling)	☐	☐
Intolerance to a variety of foods	☐	☐

28. Eyes	Yes	No
Eye pain	☐	☐
Eye strain/ sensitivity to light	☐	☐
Double vision	☐	☐
Blind spots	☐	☐
Blurred vision	☐	☐
Seeing halo around lights	☐	☐

29. Ears, Nose, and Throat	Yes	No
Earaches	☐	☐
Frequent nasal congestion	☐	☐
Sneezing frequently	☐	☐
Change in sense of smell	☐	☐
Vertigo (head spinning)	☐	☐
Ringing or noises in the ears	☐	☐
Hearing difficulty/ loss	☐	☐
Plugged Ears	☐	☐
Frequent sore throat	☐	☐
Need to clear throat	☐	☐
Post-nasal drainage	☐	☐
Tight throat	☐	☐
Changes in voice or voice difficulties	☐	☐
Difficulty swallowing	☐	☐
Lump in the throat	☐	☐

30. Oropharyngeal Disorders	Yes	No
Stomach reflux-heartburn	☐	☐
Bad breath (malodor)	☐	☐
Bad taste in mouth	☐	☐
Coating on tongue	☐	☐
Enlarged tonsils	☐	☐
Sore throat with mouth sores	☐	☐

31. Skin/Integumentary	Yes	No
Night sweats	☐	☐
Itching/burning skin	☐	☐
Skin color change	☐	☐
Sweating change	☐	☐
Temperature change of skin	☐	☐

32. Genito-Urinary	Yes	No
Urinary retention or difficulty urinating	☐	☐
Urinate frequently	☐	☐
Pain during urination	☐	☐
Blood in urine	☐	☐

33. Hematologic/Lymphatics	Yes	No
Bleed for a long time	☐	☐
Bruise easily	☐	☐
Swollen glands	☐	☐

34. Musculoskeletal/Rheumatic	Yes	No
Stiff joints	☐	☐
Swollen joints	☐	☐
Aching painful joints	☐	☐
Arm pain/tingling	☐	☐
Hand/wrist pain/carpel tunnel	☐	☐
Low back pain	☐	☐
Neck pain	☐	☐
Shoulder and upper back pain	☐	☐
Leg pain/tingling	☐	☐
Painful feet/ankles	☐	☐
Knee pain	☐	☐

35. Neurologic	Yes	No
Severe headaches	☐	☐
Wake up from headache	☐	☐
Fainting, dizzy spells or black-outs	☐	☐
Speech difficulty/slurring	☐	☐
Facial weakness/drooping	☐	☐
Facial twitching	☐	☐
Tingling or numbness in face	☐	☐
Tingling or numbness in arms/fingers	☐	☐
Hands shake or tremble	☐	☐
Memory loss	☐	☐
Balance problem	☐	☐
Weakness in parts of body	☐	☐

36. Chemical Use	Yes	No
Coffee daily	☐	☐
beer or wine daily	☐	☐
tea daily	☐	☐
cocktails or other alcoholic beverages daily	☐	☐
soft drinks(pop) daily	☐	☐
marijuana or other recreational drugs	☐	☐
cigarettes/pipe/cigar daily	☐	☐
chewing tobacco	☐	☐
cocaine or other stimulants	☐	☐
Drug/alcohol dependency (current/recovering)	☐	☐
Take alcohol or recreational drugs to help with pain	☐	☐
Immediate family members chemically dependent	☐	☐

37. Psychiatric	Yes	No
Stressed out /overwhelmed	☐	☐
Low energy level	☐	☐
Crying spells	☐	☐
Sleep problems/insomnia	☐	☐
Poor concentration	☐	☐
Trouble relaxing	☐	☐
Felt like taking your own life in past 6 months	☐	☐

COMMENTS:

DENTAL AND OROFACIAL HISTORY

38. Have you had any of the following dental treatments?	**Yes**	**No**
Orthodontic braces	☐	☐
Orthognathic or bite surgery	☐	☐
Wisdom teeth extracted	☐	☐
Other teeth extracted	☐	☐
Periodontal or gum treatment	☐	☐
Bite adjusted	☐	☐
Splint or bite guard	☐	☐
Crowns or bridge	☐	☐
Dental fillings	☐	☐
Upper full denture	☐	☐
Lower full denture	☐	☐
Upper partial denture	☐	☐
Lower partial denture	☐	☐
Mouth biopsy	☐	☐

39. Dental Problems	**Yes**	**No**
Missing teeth need replacement	☐	☐
Need new crown(s) or filling(s)	☐	☐
Problem with dentures	☐	☐
Tooth fracture(s)	☐	☐
Broken filling(s)	☐	☐
Tooth decay	☐	☐
Tooth wear	☐	☐
Persistent tooth pain	☐	☐
Tooth or teeth sensitive to hot/cold	☐	☐
Painful tooth when biting on it	☐	☐

40. TMJ and Orofacial Pain	**Yes**	**No**
Jaw pain	☐	☐
Facial pain	☐	☐
Cheek pain	☐	☐
TMJ (jaw joint) pain	☐	☐
Jaw joint clicking or popping noise	☐	☐
Jaw joint grating or crepitus noise	☐	☐
Jaw locking or getting stuck open	☐	☐
Jaw locking closed/cannot open all the way	☐	☐
Temple headache	☐	☐
Ear pain	☐	☐
Mouth pain	☐	☐
Jaw stiffness when moving it	☐	☐
Jaw pain on movement	☐	☐
Jaw pain on opening wide	☐	☐
Jaw stiffness upon wakening	☐	☐

41. Mouth Lesions or Disease	**Yes**	**No**
Burning or painful tongue	☐	☐
Dry mouth	☐	☐
Mouth sores	☐	☐
Tongue sores	☐	☐
Lips cracking or sore	☐	☐
Fever Blisters/Cold sores on lips	☐	☐
Lumps or bumps in mouth	☐	☐
Swelling in mouth	☐	☐
Mouth ulcers or canker sores	☐	☐
Colored or discolored areas in mouth	☐	☐

42. Dental Occlusion	**Yes**	**No**
Difficulty chewing due to bite	☐	☐
Malocclusion (bad bite)	☐	☐
Bite that is changing	☐	☐
Cross bite	☐	☐
Open bite	☐	☐

43. Oral Habits

Have you or others noticed yourself doing any of the following oral habits regularly (more than once a week)?	**Yes**	**No**
Chewing on one side	☐	☐
Leaning on the jaw	☐	☐
Grinding the teeth at night	☐	☐
Grinding your teeth when awake	☐	☐
Waking up with sore jaws	☐	☐
Clenching your teeth when awake	☐	☐
Clenching your teeth at night	☐	☐
Holding your jaw forward	☐	☐
Chewing gum	☐	☐
Playing a musical instrument with the mouth	☐	☐
Sleeping on stomach	☐	☐
Touching or holding your teeth together	☐	☐
Holding or pressing the tongue against your teeth	☐	☐
Holding your jaw in a rigid or tense position	☐	☐
Biting objects (pens, tooth picks, etc.)	☐	☐
Biting your cheeks	☐	☐
Biting your nails or cuticles	☐	☐
Biting your lips	☐	☐
Biting tongue	☐	☐
Bracing the phone with shoulder or jaw	☐	☐

44. Periodontal (Gums)	**Yes**	**No**
Periodontal disease	☐	☐
Gingivitis or bleeding gums	☐	☐
Loose teeth	☐	☐
Deep pockets in gums	☐	☐
Sore gums	☐	☐
Difficulty in cleaning teeth	☐	☐
Calculus (tartar build-up)	☐	☐
Impacted or unerupted teeth	☐	☐

45. Oral Obstructive Sleep/Breathing Problems	**Yes**	**No**
Snore loudly	☐	☐
Stop breathing while sleeping	☐	☐
Choke or struggle for breath while sleeping	☐	☐
Wake up at night frequently	☐	☐
Move around a lot while sleeping	☐	☐
Doze off or fall asleep during day	☐	☐
Have difficulty breathing through nose	☐	☐
Wake up feeling tired	☐	☐

46. Mouth or Facial Injury	**Yes**	**No**
Have you had trauma or injury to your jaw, head, or neck?	☐	☐

Describe:____

____

Have you or will you consult an attorney about this condition?	☐	☐

COMMENTS:

GENERAL HEALTH STATUS FORM

This questionnaire is a description of you from YOUR point of view and, thus, there are no right or wrong answers. Please respond with your first thought to each question as accurately as possible. If a question does not seem to apply to you, please answer to the best of your ability. There are three types of questions;

1) Multiple choice questions 2) Yes/No questions 3) Placement on line questions. Although the multiple choice questions and yes/no questions are probably familiar to you, the placement on line questions may not be. Here is an example of this type of question. You need to fill in the dot for both where you feel you are NOW (in the past month) as well as where you feel you SHOULD BE.

Sample: How often have you received emotional support from your family and friends?

Now ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ● ○ ○ ○ ○ ○ ○ ○ ○
Should ○ ● ○ ○ ○ ○ ○ ○

Never — Sometimes — Half of the the time — Usually — Always

5. What is your MAIN problem or complaint? (Choose only one)

○ None ○ Jaw Pain ○ Facial Pain ○ Earaches
○ Headache ○ Pain in Jaw Joint ○ Locking of Jaw ○ Inability to Open Jaw
○ Tooth Pain ○ Noises in Jaw Joint ○ Fatigue in Jaws ○ Neck Pain
○ Bite is off ○ Other________________

6. Choose one answer for each question to describe this MAIN problem:

What side is it on? ○ Right only ○ Left only ○ Both sides
What is the pattern? ○ Persistent ○ Recurrent ○ One-time
Quality of the pain? ○ Throbbing ○ Dull ○ Sharp ○ Burning ○ N/A
How many days (0-30) in the past month has it occurred? ____________

7. In the past 6 months, how OFTEN has the MAIN problem occurred?

○ ○

Never — Once a Month — Once a week — Once a day — Once an hour — Constantly

8. When the MAIN problem occurs, how LONG does it last?

○ ○

Does not occur — 1 minute — 1 hour — 1 day — 1 week — Continuous

9. How would you rate the WORST pain on a 0 to 10 scale at the PRESENT time, that is right now, where 0 is “no pain” and 10 is “pain as bad as could be”?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No pain — Pain as bad as it could be

10. In the past six months, how intense was your worst pain, rated on a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be"?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No pain — Pain as bad as it could be

11. In the past six months, ON THE AVERAGE, how intense was your pain rated on a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be"? [That is, your usual pain at times you were experiencing pain].

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No pain — Pain as bad as it could be

12. How UNPLEASANT OR DISTURBING is your usual level of this MAIN problem?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Least Imaginable — Worst Imaginable

13. What is your SECOND WORST problem or complaint? (Choose only one)

○ None	○ Jaw Pain	○ Facial Pain	○ Earaches
○ Headache	○ Pain in Jaw Joint	○ Locking of Jaw	○ Inability to Open Jaw
○ Tooth Pain	○ Noises in Jaw Joint	○ Fatigue in Jaws	○ Neck Pain
○ Bite is off	○ Other________________		

14. If present, choose one answer for each question to describe your 2nd worst problem:

What side is it on?	○Right only	○ Left only	○Both sides		
What is the pattern?	○Persistent	○ Recurrent	○One-time		
Quality of the pain?	○Throbbing	○ Dull	○ Sharp	○ Burning	○ N/A
How long does it last?	○It's gone	○ Minutes	○ Hours	○ Days	○ Constant

How many days (0-30) in the past month has it occurred? ____________

How intense is it usually on a 0 to 10 scale (10 is the worst)? ____________

15. What is your THIRD WORST problem or complaint? (Choose only one)

○ None	○ Jaw Pain	○ Facial Pain	○ Earaches
○ Headache	○ Pain in Jaw Joint	○ Locking of Jaw	○ Inability to Open Jaw
○ Tooth Pain	○ Noises in Jaw Joint	○ Fatigue in Jaws	○ Neck Pain
○ Bite is off	○ Other________________		

16. If present, choose one answer for each question to describe your 3rd worst problem:

What side is it on?	○Right only	○ Left only	○Both sides		
What is the pattern?	○Persistent	○ Recurrent	○One-time		
Quality of the pain?	○Throbbing	○ Dull	○ Sharp	○ Burning	○ N/A
How long does it last?	○It's gone	○ Minutes	○ Hours	○ Days	○ Constant

How many days (0-30) in the past month has it occurred? ____________

How intense is it usually on a 0 to 10 scale (10 is the worst)? ____________

17. If you have HEADACHES, please answer the following questions about them:

Where does it occur? ○ Temple ○ Forehead ○ Top of head ○ Side of head ○ Base of head

What side is it on? ○ Right only ○ Left only ○ Both sides

What is the pattern? ○ Persistent ○ Recurrent ○ One-time

Quality of the headache? ○Throbbing ○ Dull ○ Sharp ○ Burning ○ N/A How long does it last? ○It's gone ○ Minutes ○ Hours ○ Days ○ Constant

How many days (0-30) in the past month has it occurred? ___________

How intense is it usually on a 0 to 10 scale (10 is the worst)? ___________

When it occurs, do you have any: ○ Nausea ○ Vomiting ○ Sensitivity to light ○ Sensitivity to noise

Right before it occurs, do you have any: ○ Speech changes ○ Vision changes ○ Weakness ○ Other sensations:______________

Please answer the following questions about all of the above problems.

18. How difficult is it to ENDURE OR TOLERATE the problem(s) over time?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Least imaginable Worst imaginable

19. In the past six months, how much has the problem interfered with your daily activities rated on a 0 to 10 scale where 0 is "no interference" and 10 is "unable to carry on any activities"?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No interference Unable to carry on any activities

20. In the past six months, how much has the problem(s) changed your ability to take part in RECREATIONAL, SOCIAL AND FAMILY ACTIVITIES where 0 is "no change" and 10 is "extreme change"?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No change Extreme change

21. In the past six months, how much has the problem(s) changed your ABILITY TO WORK (including housework) where 0 is "no change" and 10 is "extreme change"?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

No change Extreme change

22. About how many days in the LAST SIX MONTHS (180 days) have you been kept from your usual activities (work, school or housework) because of the problem(s)?

______________ (0-180) Days

23. What activities does the problem(s) prevent or limit you from doing?

Activity	Yes	No	Activity	Yes	No
swallowing……………………………..	☐	☐	chewing………………………………..	☐	☐
eating hard food……………………….	☐	☐	drinking…………………………………	☐	☐
eating soft foods…………………..…..	☐	☐	exercising………………………………	☐	☐
maintaining normal weight………….	☐	☐	cleaning teeth or face…………………	☐	☐
yawning…………………………………	☐	☐	having your usual facial appearance..	☐	☐
talking……………………………………	☐	☐	sexual activity………………………….	☐	☐
smiling/laughing………………………..	☐	☐			

24. What other activities do all health problems prevent or limit you from doing?

Activity	Yes	No	Activity	Yes	No
Working	☐	☐	Riding in the car or bus	☐	☐
Driving	☐	☐	Fixing meals	☐	☐
Household chores	☐	☐	Yard work	☐	☐
Walking long distances	☐	☐	Active sports	☐	☐
Hard exercise	☐	☐	Mild exercise	☐	☐
Active hobbies	☐	☐	Reading	☐	☐
Sitting for hours	☐	☐	Standing for hours	☐	☐
Socializing with friends or family	☐	☐	Discussing personal problems	☐	☐
Sleeping	☐	☐			

25. When was the problem first noticed? ____/____/______ (mm/dd/yy)

26. The problem began with (check all that apply):

- ○ Jaw surgery
- ○ Dental work
- ○ Orthodontics (braces)
- ○ Work accident
- ○ Blow to jaw/head/neck
- ○ Chewing
- ○ Stressful situation
- ○ Athletic injury
- ○ Motor vehicle accident
- ○ Tooth extraction
- ○ Nothing, pain just came on
- ○ Other____________________

27. Please describe the onset of your problem:

28. Which TESTS have you had for the problem? (check all that apply)

- ○ None
- ○ Other xrays
- ○ Venogram/arteriogram
- ○ Arthrogram in the joint
- ○ Myelogram
- ○ Jaw tracking
- ○ Other_______________
- ○ TMJ x-ray
- ○ EMG (electromyography)
- ○ MR scan (magnetic resonance)
- ○ Nerve block (injection)
- ○ Diet analysis
- ○ Bone scan
- ○ Panoramic xrays
- ○ Urine studies
- ○ Blood studies
- ○ CT scan (CAT)
- ○ Thermogram
- ○ Tooth pulp test

29. Which of these HEALTH/HELPING PROFESSIONALS have you seen for the problem? (check all that apply)

- ○ None
- ○ Orthodontist
- ○ Ear/Nose/Throat
- ○ Neurologist
- ○ Orthopedic Surgeon
- ○ Oral Surgeon
- ○ Physical Medicine Specialist
- ○ General Practitioner (M.D.)
- ○ Acupuncturist
- ○ Anesthesiologist
- ○ Ophthalmologist
- ○ Dentist
- ○ Rheumatologist
- ○ Psychiatrist
- ○ Occupational Therapist
- ○ Other_____________________
- ○ 'insurance' Physician/Dentist
- ○ Internist
- ○ TMJ specialist
- ○ Psychologist
- ○ Neurosurgeon
- ○ Physical Therapist
- ○ Chiropractor

30. Which TREATMENTS have you had for the problem? (check all that apply)

- ○ No treatment
- ○ Electrical stimulation (TENS)
- ○ Ultrasound or iontophoresis
- ○ Root canal/dental treatment
- ○ Exercise
- ○ Neurosurgery
- ○ Orthodontic/braces
- ○ Chiropractic treatment
- ○ Traction
- ○ Injections/nerve blocks
- ○ Acupuncture
- ○ Massage/acupressure
- ○ Biofeedback
- ○ TMJ surgery without implants
- ○ Pain program
- ○ Botox injections
- ○ Splints or bite planes
- ○ Counseling
- ○ Medications
- ○ Heat/cold applications
- ○ Stress management
- ○ TMJ implant surgery
- ○ Hypnosis
- ○ Other________________

31. How many EMERGENCY ROOM VISITS (for any reason) have you had in the past year?

○ 0 ○ 1 ○ 2 or 3 ○ 4 or 5 ○ 6 or more

32. What is the total number of DIFFERENT KINDS OF PILLS or MEDICINES (any type, except vitamins) that you take daily?

○ 0 ○1 to 2 ○ 3 to 4 ○ 5 to 6 ○ 7 or more

33. How many days did you spend IN THE HOSPITAL during the past year?

○ 0 ○ 1 to 3 ○ 4 to 6 ○ 7 to 14 ○ 15 or more

34. How often have you been seen by HEALTH PROFESSIONALS (for any reason) in the last year?

○ ○

Daily — Once a Week — Once a month — Once every 3 months — Not at all

35. How many SURGERIES have you had for a jaw joint (TMJ) problem? Right: ____Left: ____

36. If you have had TMJ surgery, please check the type of surgeries you have had.

O No surgery

	right	left		right	left
Arthroscopic surgery…………….....	○	○	TMJ disk removal……………………..	○	○
Orthognathic surgery……………...	○	○	TMJ disk implant removal……………	○	○
TMJ disk implant placed…………..	○	○	Arthroplasty…………………………….	○	○
Total synthetic joint placement…...	○	○	Arthrocentesis/lysis and lavage……..	○	○
TMJ disk repair……………...…...	○	○	Arthrotomy……………………………..	○	○
Other______________________	○	○			

37. If you have had a TMJ implant, please check the type of implant(s) that you have had.

O No Implants

	right	left		right	left
Silicone/Silastic® disk (permanent)	○	○	Lorenz/Biomet…………………….....	○	○
Silicone/Silastic® disk (temporary)	○	○	Proplast/teflon® disk…………………	○	○
Christensen (TMJ, Inc) joint……....	○	○	Techmedica/TMJ Concepts joint…....	○	○
Hoffman-Pappas/Endotec joint…..	○	○	Kent/Vitek joint………………………..	○	○
Other:_____________________	○	○			

38. Please check any side effects you have had from TMJ treatment or TMJ surgery;

O No Side Effects

	right	left		right	left
Facial or jaw swelling……………	○	○	Asymmetry of the face……………	○	○
Facial muscle weakness………..	○	○	Objectionable scarring……………..	○	○
Allergic reaction to drugs……….	○	○	Bruising or discoloration…………..	○	○
Numbness to skin………………..	○	○	Change in bite………………………	○	○
Worsening of pain………………	○	○	Difficulty opening jaw……………....	○	○
Ear ringing………………………..	○	○	Difficulty chewing…………………...	○	○
Ear plugged…………………….	○	○	Infection……………………………....	○	○
Ear pain…………………………..	○	○	TMJ noise or crepitus………..….....	○	○
Dental problems………………….	○	○	Eye brow weakness………….…….	○	○

39. How many years has this problem or other health problems affected your life?

○ less than 1 ○ 1 to 2 ○ 3 to 4 ○ 5 to 10 ○ 11 to 19 ○ 20 or more

MULTIDIMENSIONAL PAIN INVENTORY

Kerns, Turk & Rudy (1985)

THE FOLLOWING SECTION ASKES YOU IMPORTANT QUESTIONS ABOUT YOUR PAIN. PLEASE RESPOND TO EACH QUESTION.

BEFORE YOU BEGIN, PLEASE ANSWER 2 PRE-EVALUATION QUESTIONS BELOW:

1. Some of the questions in this questionnaire refer to your “significant other”. A significant other is a person with whom you feel closest. This includes anyone that you relate to on a regular or infrequent basis. It is very important that you identify someone as your “significant other”. Please indicate below who your significant other is (check one):

□Spouse □Partner/Companion □Housemate/Roomate
□Friend □Neighbor □Parent/Child/Other relative
□Other (please describe):____________________________

2. Do you currently live with this person? □ YES □ NO

When you answer questions in the following pages about “your significant other”, always respond in reference to the specific person you just indicated above.

A. In the following 20 questions, you will be asked to describe your pain and how it affects your life. Under each question is a scale to record your answer. Read each question carefully and then circle a number on the scale under that question to indicate how that specific question applies to you.

1. Rate the level of your pain at the present moment.

   0 1 2 3 4 5 6
   No pain Very intense pain

2. In general, how much does your pain problem interfere with your day to day activities?

   0 1 2 3 4 5 6
   No interference Extreme interference

3. Since the time you developed a pain problem, how much has your pain changed your ability to work?

   0 1 2 3 4 5 6
   No change Extreme change

   ___ Check here, if you have retired for reasons other than your pain problem

4. How much has your pain changed the amount of satisfaction or enjoyment you get from participating in social and recreational activities?

   0 1 2 3 4 5 6
   No change Extreme change

5. How supportive or helpful is your spouse (significant other) to you in relation to your pain?

   0 1 2 3 4 5 6
   Not at all supportive Extremely supportive

6. Rate your overall mood during the past week.

   0 1 2 3 4 5 6
   Extremely low mood Extremely high mood

7. On the average, how severe has your pain been during the last week?

   0 1 2 3 4 5 6
   Not at all severe Extremely severe

8. How much has your pain changed your ability to participate in recreational and other social activities?

   0 1 2 3 4 5 6
   No change Extreme change

9. How much has your pain changed the amount of satisfaction you get from family-related activities?

   0 1 2 3 4 5 6
   No change Extreme change

10. How worried is your spouse (significant other) about you in relation to your pain problem?

    0 1 2 3 4 5 6
    Not at all worried Extremely worried

11. During the past week, how much control do you feel that you have had over your life?

    0 1 2 3 4 5 6
    Not at all in control Extremely in control

12. How much suffering do you experience because of your pain?

    0 1 2 3 4 5 6
    No suffering Extreme suffering

13. How much has your pain changed your marriage and other family relationships?

0 1 2 3 4 5 6
No change Extreme change

14. How much has your pain changed the amount of satisfaction or enjoyment you get from work?

0 1 2 3 4 5 6
No change Extreme change

__ Check here, if you are not presently working.

15. How attentive is your spouse (significant other) to your pain problem?

0 1 2 3 4 5 6
Not at all attentive Extremely attentive

16. During the past week, how much do you feel that you've been able to deal with your problems?

0 1 2 3 4 5 6
Not at all Extremely well

17. How much has your pain changed your ability to do household chores?

0 1 2 3 4 5 6
No change Extreme change

18. During the past week, how irritable have you been?

0 1 2 3 4 5 6
Not at all irritable Extremely irritable

19. How much has your pain changed your friendships with people other than your family?

0 1 2 3 4 5 6
No change Extreme change

20. During the past week, how tense or anxious have you been?

0 1 2 3 4 5 6
Not at all tense or anxious Extremely tense or anxious

B. In this section, we are interested in knowing how your significant other (this refers to the person you indicated above) responds to you when he or she knows that you are in pain. On the scale listed below each question, **circle a number** to indicate how often your significant other generally responds to you in that particular way when you are in pain.

1. Ignores me.

   0 1 2 3 4 5 6
   Never Very often

2. Asks me what he/she can do to help.

   0 1 2 3 4 5 6
   Never Very often

3. Reads to me.

   0 1 2 3 4 5 6
   Never Very often

4. Expresses irritation at me.

   0 1 2 3 4 5 6
   Never Very often

5. Takes over my jobs or duties.

   0 1 2 3 4 5 6
   Never Very often

6. Talks to me about something else to take my mind off the pain.

   0 1 2 3 4 5 6
   Never Very often

7. Expresses frustration at me.

   0 1 2 3 4 5 6
   Never Very often

8. Tries to get me to rest.

   0 1 2 3 4 5 6
   Never Very often

9. Tries to involve me in some activity

0 1 2 3 4 5 6
Never Very often

10. Expresses anger at me.

0 1 2 3 4 5 6
Never Very often

11. Gets me some pain medications.

0 1 2 3 4 5 6
Never Very often

12. Encourages me to work on a hobby.

0 1 2 3 4 5 6
Never Very often

13. Gets me something to eat or drink.

0 1 2 3 4 5 6
Never Very often

14. Turns on the T.V. to take my mind off my pain

0 1 2 3 4 5 6
Never Very often

C. Listed below are 18 common daily activities. Please indicate how often you do each of these activities by circling a number on the scale listed below each activity. Please complete all 18 questions.

1. Wash dishes.

0 1 2 3 4 5 6
Never Very often

2. Mow the lawn.

0 1 2 3 4 5 6
Never Very often

3. Go out to eat.

0 1 2 3 4 5 6
Never Very often

4. Play cards or other games.

0 1 2 3 4 5 6
Never Very often

5. Go grocery shopping.

0 1 2 3 4 5 6
Never Very often

6. Work in the garden.

0 1 2 3 4 5 6
Never Very often

7. Go to a movie.

0 1 2 3 4 5 6
Never Very often

8. Visit friends.

0 1 2 3 4 5 6
Never Very often

9. Help with the house cleaning.

0 1 2 3 4 5 6
Never Very often

10. Work on the car.

0 1 2 3 4 5 6
Never Very often

11. Take a ride in a car.

0 1 2 3 4 5 6
Never Very often

12. Visit relatives.

0	1	2	3	4	5	6
Never						Very often

13. Prepare a meal.

0	1	2	3	4	5	6
Never						Very often

14. Wash the car.

0	1	2	3	4	5	6
Never						Very often

15. Take a trip.

0	1	2	3	4	5	6
Never						Very often

16. Go to a park or beach.

0	1	2	3	4	5	6
Never						Very often

17. Do a load of laundry.

0	1	2	3	4	5	6
Never						Very often

18. Work on a needed house repair.

0	1	2	3	4	5	6
Never						Very often

Please choose the words below that describe your pain *today*. If a word does not describe your pain, choose the 0 (*none*) for that word. For each word that does describe your pain, rate the intensity for that quality of your pain from 1 (*mild*) to 3 (*severe*).

	None	Mild	Moderate	Severe
Throbbing	0) ______	1) ______	2) ______	3) ______
Shooting	0) ______	1) ______	2) ______	3) ______
Stabbing	0) ______	1) ______	2) ______	3) ______
Sharp	0) ______	1) ______	2) ______	3) ______
Cramping	0) ______	1) ______	2) ______	3) ______
Gnawing	0) ______	1) ______	2) ______	3) ______
Hot-burning	0) ______	1) ______	2) ______	3) ______
Aching	0) ______	1) ______	2) ______	3) ______
Heavy	0) ______	1) ______	2) ______	3) ______
Tender	0) ______	1) ______	2) ______	3) ______
Splitting	0) ______	1) ______	2) ______	3) ______
Tiring-exhausting	0) ______	1) ______	2) ______	3) ______
Sickening	0) ______	1) ______	2) ______	3) ______
Fearful	0) ______	1) ______	2) ______	3) ______
Punishing-cruel	0) ______	1) ______	2) ______	3) ______

Please mark an "X" on the line below to show how bad your pain is right now.

No Pain |————————————————————| Worst Possible Pain

Please mark below your present pain intensity and typical pain frequency.

Mark your present pain intensity:

____ 0 No pain
____ 1 Mild
____ 2 Discomforting
____ 3 Distressing
____ 4 Horrible
____ 5 Excruciating

My pain is usually present

____ 1 Briefly
____ 2 It come and goes
____ 3 It's constant

Thoughts and Feelings about your Pain

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery. We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 - not at all 1 - to a slight degree 2 - to a moderate degree 3 - to a great degree 4 - all the time

1.______ I worry all the time about whether it will end.
2.______ I feel I can't go on.
3.______ It's terrible and I think it's never going to get any better.
4.______ It's awful and I feel that it overwhelms me.
5.______ I feel I can't stand it anymore.
6.______ I become afraid that the pain will get worse.
7.______ I keep thinking of other painful events.
8.______ I anxiously want the pain to go away.
9.______ I can't seem to get it out of my mind.
10.______I keep thinking about how much it hurts.
11.______I keep thinking about how badly I want the pain to stop.
12.______There's nothing I can do to reduce the intensity of the pain.
13.______I wonder whether something serious may happen.
14.______I feel my life isn't worth living.

Below is a list of the ways you might have felt or behaved. Please check (X) how often you have felt this way during the past week.	DURING THE PAST WEEK			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people dislike me.				
20. I could not get "going."				

Please answer each of the questions below by circling the number that best describes your sleep patterns ***in the past week.*** Please answer all questions.

Please rate the current (past week's) **SEVERITY** of your insomnia problem(s):	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep					
Difficulty staying asleep					
Problem waking up too early					

How **SATISFIED/DISSATISFIED** are you with your current sleep pattern?	Very Satisfied 0	Satisfied 1	Neutral 2	Dissatisfied 3	Very Dissatisfied 4

To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (eg, daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc)?	Not at all Interfering 0	A Little 1	Somewhat 2	Much 3	Very Much Interfering 4

How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?	Not at all Noticeable 0	A Little 1	Somewhat 2	Much 3	Very Much Noticeable 4

How **WORRIED/DISTRESSED** are you about your current sleep problem?	Not at all Worried 0	A Little 1	Somewhat 2	Much 3	Very Much Worried 4