CMF CRANIOMAXILLOFACIAL SURGERY ASSOCIATES

TMJ QUESTIONNAIRE

Patient Name _____ **Date:** _____

CHIEF COMPLAINT:

- What is the main problem that brings you here? _____

  _____

- Did this problem begin: **SUDDENLY** ☐ **GRADUALLY** ☐
- How long have you been bothered by this problem? **YEARS MONTHS WEEKS DAYS**

PAIN SYMPTOMS:

- Location (please circle all locations that you are having pain. Circle **R** for right, **L** for left)

Joint	**R** ☐	**L** ☐
Ear	**R** ☐	**L** ☐
Upper teeth/jaw	**R** ☐	**L** ☐
Lower teeth/jaw	**R** ☐	**L** ☐
Eyes	**R** ☐	**L** ☐
Face	**R** ☐	**L** ☐
Shoulders	**R** ☐	**L** ☐
Forehead	**R** ☐	**L** ☐
Neck	**R** ☐	**L** ☐

- Headaches (answer only if you have regular headaches)

  How often? _____
  Time of Day _____
  Location: **ONE SIDE** ☐ **BOTH SIDES** ☐
  Previous Diagnosis and Treatment: _____

- Circle all the terms that describe your pain:

☐**SHARP** ☐**DULL** ☐**ACHING** ☐**DEEP** ☐ **SUPERFICIAL** ☐ **BURNING** ☐ **PULSING** ☐**SPREADING**

- Rate your pain today by placing a line on the following scale:

NONE *WORST*

0----------100

- Is this pain: ☐ **CONSTANT** ☐ **INTERMITTENT**
- Does the pain last for: ☐ **MINUTES** ☐ **HOURS**
- Does the pain start: ☐ **SUDDENLY** ☐ **GRADUALLY**

- Does the pain stop: **SUDDENLY** ☐ **GRADUALLY** ☐
- What time of the day is the pain most severe? _____
- What is the longest period of time you have gone with pain? _____
- What medication, if any, do you take for pain? _____
- Does rest increase or decrease the pain? _____
- Does positioning your head or jaw in a certain position relieve pain? **YES** ☐ **NO** ☐

  Briefly describe: _____
- Do any normal activities cause pain? **YES** ☐ **NO** ☐

  Briefly describe: _____

DYSFUNCTION:

- Can you open your mouth: **NORMALLY** ☐ **PARTIALLY** ☐ **VERY LIMITED** ☐
- Has your jaw ever locked open or shut: **YES** ☐ **NO** ☐
- Do you have any of these sounds in your jaw joints?

  GRATING: **R** ☐ **L** ☐ **CLICKING:** **R** ☐ **L** ☐

  SNAPPING: **R** ☐ **L** ☐ **POPPING:** **R** ☐ **L** ☐
- If you have any of these problems, is it: **FREQUENTLY** ☐ **OCCASIONALLY** ☐ **CONSTANTLY** ☐
- Have you noticed any change in your bite or ability to chew? **YES** ☐ **NO** ☐

OTHER COMPLAINTS & QUESTIONS:

- Do you have problems with your ears? **YES** ☐ **NO** ☐

  If yes, are the problems: **PAIN** ☐ **DIZZINESS** ☐ **RINGING** ☐ **OTHER:**_____
- Are your jaws clenched or teeth sore when you awaken from sleep? **YES** ☐ **NO** ☐
- Do you grind or clench your teeth? **YES** ☐ **NO** ☐
- Do you chew gum or ice? **YES** ☐ **NO** ☐
- Are your muscles ever tired? **YES** ☐ **NO** ☐
- Have you had orthodontic treatment (braces)? **YES** ☐ **NO** ☐
- Have you ever had your bite adjusted by your dentist? **YES** ☐ **NO** ☐
- Do you play a musical instrument or sing? **YES** ☐ **NO** ☐

Please list any other pertinent information you feel we should know: _____

_____

_____

Have you been treated previously for this problem? _____

By Whom: _____ Telephone: _____

Diagnosis & Treatment: _____

_____

CRANIOMAXILLOFACIAL SURGERY ASSOCIATES

Experts in Facial Aesthetic and Reconstructive Surgery

TMJ - Surgery
Quality of Life Questionnaire

A. PAIN?

1. I have no pain
2. There is mild pain but I do not need medication
3. I have moderate pain which requires regular analgesics eg: Paracetamol
4. I have severe pain controlled only by strong analgesics eg: Panadeine forte
5. I have severe pain which is not controlled by analgesics.

B. DIET & CHEWING?

1. I can chew and eat whatever I like
2. I can chew most things except tough foods like steak and apples
3. I only stick to soft foods such as pasta and soft bread
4. I need to cut up all food into small pieces
5. I can only eat food that has been put through the blender

C. SPEECH?

1. My speech is normal
2. I have difficulty in saying some words
3. I have difficulty in being understood over the telephone
4. Only my friends and family can understand me
5. I cannot be understood at all

D. ACTIVITY?

1. I am as active as I have ever been
2. There are times where I can't keep up my old pace, but not often
3. I am often tired and have slowed down my activities though I still get out
4. I don't go out very often because I don't have the strength
5. I am usually in bed or chair and don't leave home

E. RECREATION?

1. There are no limitations to recreation at home or away from home
2. There are a few things I can't do but I still get out and enjoy life
3. There are many times where I wish I could get out more, but I am not up to it
4. There are severe limitations to what I can do, mostly I stay at home and watch TV
5. I can't do anything enjoyable.

F. MOOD?

1. My mood is excellent and unaffected by my TMJ disorder
2. My mood is generally good and only occasionally affected *my* TMJ disorder
3. I am neither in a good mood nor depressed about my TMJ disorder
4. I am somewhat depressed about my TMJ disorder
5. I am extremely depressed about my TMJ disorder

G. ANXIETY?

1. I am not anxious about my TMJ disorder
2. I am a little anxious about *my* TMJ disorder but I am coping
3. I am very anxious about my TMJ disorder and finding it difficult coping
4. I am severely anxious about *my* TMJ disorder and not coping at all

H. Considering everything in your life that contributes to your personal well-being such as family, friends, spirituality and personal leisure activities, please rate your overall quality of life over the past month:

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

Please answer the 36 questions of the **Health Survey** completely, honestly, and without interruptions.

GENERAL HEALTH:
In general, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health in general now?

☐ Much better now than one year ago
☐ Somewhat better now than one year ago
☐ About the same
☐ Somewhat worse now than one year ago
☐ Much worse than one year ago

LIMITATIONS OF ACTIVITIES:
The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.

☐ Yes, Limited a lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Lifting or carrying groceries

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Climbing several flights of stairs

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Climbing one flight of stairs

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Bending, kneeling, or stooping

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Walking more than a mile

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Walking several blocks

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Walking one block

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

Bathing or dressing yourself

☐ Yes, Limited a Lot ☐ Yes, Limited a Little ☐ No, Not Limited at all

PHYSICAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Cut down the amount of time you spent on work or other activities

☐ Yes ☐ No

Accomplished less than you would like

☐ Yes ☐ No

Were limited in the kind of work or other activities

☐ Yes ☐ No

Had difficulty performing the work or other activities (for example, it took extra effort)

☐ Yes ☐ No

EMOTIONAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

Cut down the amount of time you spent on work or other activities

☐ Yes ☐ No

Accomplished less than you would like

☐ Yes ☐ No

Didn't do work or other activities as carefully as usual

☐ Yes ☐ No

SOCIAL ACTIVITIES:

Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Severe ☐ Very Severe

PAIN:

How much bodily pain have you had during the past 4 weeks?

☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

ENERGY AND EMOTIONS:
These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.

Did you feel full of pep?
- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Have you been a very nervous person?
- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Have you felt so down in the dumps that nothing could cheer you up?
- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Have you felt calm and peaceful?
- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Did you have a lot of energy?
- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Have you felt downhearted and blue?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Did you feel worn out?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Have you been a happy person?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

Did you feel tired?

- ☐ All of the time
- ☐ Most of the time
- ☐ A good Bit of the Time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

SOCIAL ACTIVITIES:

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the Time

GENERAL HEALTH:
How true or false is each of the following statements for you?

I seem to get sick a little easier than other people
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

I am as healthy as anybody I know
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

I expect my health to get worse
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false

My health is excellent
☐ Definitely true ☐ Mostly true ☐ Don't know ☐ Mostly false ☐ Definitely false