

Orofacial Pain Questionnaire

Date: _____

Name: _____ Age: _____ Sex: M / F

1. Do you have jaw joint pain?

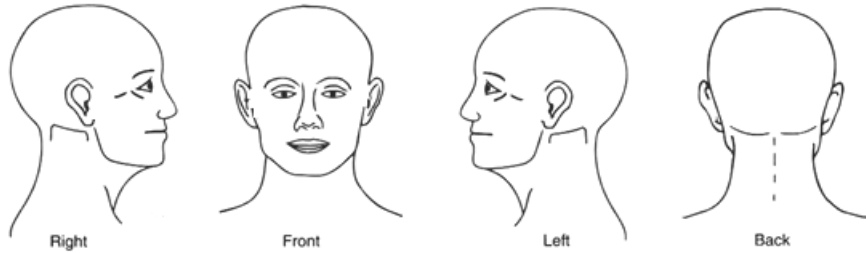
____ No ____ Right ____ Left ____ Both

2. Do you have ____ ear pain? ____ hearing problems? ____ dizziness? ____ other?

____ No ____ Right ____ Left ____ Both

3. Do you have other pain in the jaw, face, or neck?

____ No ____ Yes - Where? (mark below)



4. How often does this pain bother you?

- ____ every day
- ____ 3-5 days per week
- ____ a couple of days per week
- ____ a couple of days per month

5. How long have you had this pain? _____

6. Is the pain - ____ constant? ____ worse in the morning? ____ worse in the evening?

- Describe it: ____ aching ____ shooting ____ burning ____ stabbing
- ____ electrical ____ other (describe _____)

7. Do you have headaches?

<input type="checkbox"/> none	<input type="checkbox"/> Right	<input type="checkbox"/> Frontal
<input type="checkbox"/> a couple of days per month	<input type="checkbox"/> Left	<input type="checkbox"/> Temporal
<input type="checkbox"/> a couple of days per week	<input type="checkbox"/> Both sides	<input type="checkbox"/> Back/neck
<input type="checkbox"/> every day		<input type="checkbox"/> Behind the eyes

8. On the scale indicate your pain intensity. The left side represents NO PAIN and the right side represents EXTREME PAIN that is as bad as you could imagine. Draw a line from **left to right** to demonstrate your pain intensity.

No Pain Extreme Pain

9. Are you aware of your jaw making noises?

During Chewing: No Right Left Both
On extreme Opening: No Right Left Both

o Describe the noise: popping grinding other (“_____”)

10. Do you have pain when you chew?

No Right Left Both

11. Do you have pain when you open wide or take a big bite?

No Right Left Both

12. Are certain foods difficult to chew

No tough foods (bagels, steak) lettuce thick sandwiches

13. Does the pain or discomfort interfere with your work, activities, or life-style? No. Explain if yes _____.

14. Do you take medication for the pain or discomfort? No Yes

What medications do you take and how often do you take them? _____

15. Have you ever had difficulty opening your jaw? ___ No ___ Yes
 ○ How did you get your jaw opened? _____
16. Has your jaw ever “locked open” or “slipped out of place”? ___ No ___ Yes
 ○ How did you get your jaw closed? _____
17. Have you ever been in an accident or received a blow to the face?
 ___ No ___ Yes – describe _____
18. Is there any other precipitating event that would lead you to believe that it may have caused your pain? ___ No ___ Yes – describe _____

19. Have you ever had general anesthesia? ___ No ___ Yes–specify _____
20. Are you aware of clenching or grinding your teeth?
 ___ No ___ During the day ___ At night ___ When you are stressed
21. Do you have any of the following habits? ___ fingernail biter ___ gum chewer
 ___ pencil biter ___ cheek biter ___ pipe stem biter ___ play musical instrument
 ___ telephone on shoulder ___ other - _____
22. Have you had any dental work done recently? ___ No ___ Yes – ___ extractions
 ___ orthodontics ___ fillings ___ crowns ___ dentures
23. Does anyone else in your family have jaw pain?
 ___ No ___ Yes - specify _____
24. Has another Doctor treated you for this problem? ___ No ___ Yes

If so, name _____
 Address _____
 Treatment _____