TMJ/SLEEP QUESTIONAIRE

Name: _____

Date:_____

DO YOU EXPERIENCE ANY OF THE FOLLOWING:

YES_____ NO_____ 1. Popping or grinding in jaw joints?

YES_____ NO_____ 2. Headaches in the temple or back of head?

YES_____ NO_____ 3. Pain or tension in your neck or shoulders?

YES_____ NO_____ 4. Stuffiness or ringing in your ears?

YES_____ NO_____ 5. Are your jaws clenched when you awaken from sleep or do you grind your teeth?

YES_____ NO_____ 6. Fatigue upon chewing or talking?

YES_____ NO_____ 7. Pain upon wide opening of your mouth?

YES_____ NO_____ 8. Do you snore

YES_____ NO_____ 9. Are you tired during the day?

YES_____ NO_____ 10. Has anyone ever told you that you stopped breathing while you sleep?

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YES_____ NO_____ 11. Do you have high blood pressure?

PLEASE FILL OUT COMPLETELY