

# FAMILY DENTISTRY at the LAKES

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TMJ Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Address \_\_\_\_\_ City / State / Zip \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_ Referred by  
Dr.: \_\_\_\_\_

Do you ever have headaches? \_\_\_\_\_ If yes, how  
often? \_\_\_\_\_

Do you ever have pain in your Ear? \_\_\_\_\_ Face? \_\_\_\_\_ Eye? \_\_\_\_\_ Neck? \_\_\_\_\_

Jaw? \_\_\_\_\_ Other? \_\_\_\_\_

Which side of your jaw hurts? Right Left Both (circle the one that applies)

How long have you had these symptoms? Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Is the pain constant? \_\_\_\_\_ Aching? \_\_\_\_\_ Burning? \_\_\_\_\_ Stabbing pain? \_\_\_\_\_

Is pain worse in the morning? \_\_\_\_\_ Afternoon? \_\_\_\_\_ Night? \_\_\_\_\_

Does it hurt to chew? \_\_\_\_\_ Does it hurt to open your mouth wide? \_\_\_\_\_ Other? \_\_\_\_\_

Does your jaw make a popping noise? \_\_\_\_\_ Clicking noise? \_\_\_\_\_ Grinding noise? \_\_\_\_\_

Has your jaw ever "locked" or slipped out of place? \_\_\_\_\_ Other \_\_\_\_\_

Do you ever clench or grind your teeth? \_\_\_\_\_ During the day? \_\_\_\_\_ At night? \_\_\_\_\_

Do you have problems with your ears? \_\_\_\_\_ Trouble hearing? \_\_\_\_\_ Dizziness? \_\_\_\_\_

Is it painful to swallow? \_\_\_\_\_

Are your teeth ever sore or sensitive? \_\_\_\_\_ If yes,  
when?: \_\_\_\_\_

Are you taking any medication of any kind? \_\_\_\_\_ If yes, name medicine and reason \_\_\_\_\_

Describe the problem in your own words: \_\_\_\_\_