JACK H. LEVERETT, D.D.S., P.C.

JACK H. LEVERETT, JR., D.M.D., A.B.G.D.

Temporomandibular Joint / Dysfunction (TMJ/TMD)

Screening Questionnaire

Name _____ **Date of birth** _____

CURRENT SYMPTOMS -

Please provide information about your current symptoms and rank them according to your level of concern:

	# Concern	**How often/when/duration?**	**How painful?** (on a scale of 0 to 5)
Headaches	_____	_____	_____
Facial Pain	_____	_____	_____
Jaw clenching	_____	_____	_____
Neck pain	_____	_____	_____
Trouble speaking	_____	_____	_____
Difficulty swallowing	_____	_____	_____
Jaw popping/clicking	_____	_____	_____
Difficulty opening mouth/jaw tightness	_____	_____	_____
Bite feels off	_____	_____	_____

Symptoms that accompany headaches (please mark all that apply)

_____ Ear Pain/Ringing decreased hearing _____ Dizziness _____ Sensitive to light

_____ Vision problems _____ Nausea / vomiting _____ Exhaustion/fatigue

Do you snore? Yes No

Please describe any other symptoms:

_____

_____

MEDICAL HISTORY - Please indicate if you have ever been treated for:

	When	Medications taken /Appliances used	Status today
Migraine Headaches	_____	_____	_____
Tension Headaches	_____	_____	_____
Sleep Apnea	_____	_____	_____