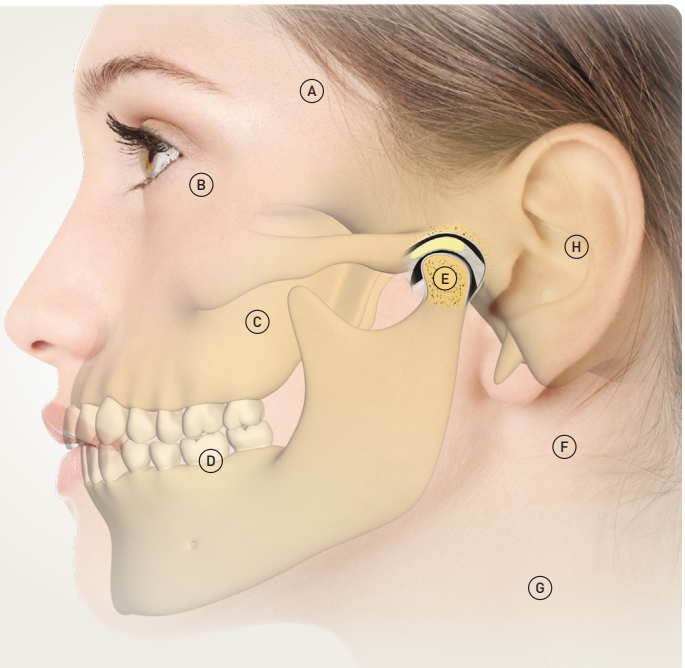
PATIENT USE ONLY

TMJBDS® PATIENT QUESTIONNAIRE

Facial pain, headaches, neck/shoulder soreness, night-time snoring and daytime fatigue are all symptoms of TMJBDS®.

Dysfunction relating to the teeth, muscles, jaws, breathing and/or sleep can result in a wide range of symptoms that may seem unrelated. However, in most cases, they are all a part of a singular health problem - *TMJBDS®*. Symptoms will often occur simultaneously because the causes of jaw joint dysfunction and sleep-related breathing disorders are interrelated.

If the root cause of this pain is *TMJBDS®*, multiple symptoms below will be present. The following questionnaire will help determine if you have *TMJBDS®* and if help can be provided at our clinic.



TMJBDS® SYMPTOMS - QUESTIONNAIRE

Ⓐ Head Pain, Headache Problems, Facial Pain

- ☐ Forehead (frontal)
- ☐ Temples (temporal)
- ☐ 'Migraine' type headache
- ☐ 'Cluster' headache
- ☐ Maxillary sinus headache (under the eyes)
- ☐ Headaches at the back of the head

Ⓑ Eye Pain and Eye Orbital Problems

- ☐ Eye (orbital) pain; above, below, behind
- ☐ Bloodshot eyes (hyperemia)
- ☐ Blurring of vision
- ☐ Bulging appearance
- ☐ Pressure behind the eyes
- ☐ Light sensitivity (photophobia)
- ☐ Watering of the eyes

Ⓒ Mouth, Face, Cheek, and Chin Problems

- ☐ Discomfort
- ☐ Limited opening
- ☐ Inability to open smoothly, evenly
- ☐ Jaw deviates to one side when opening
- ☐ Inability to 'find bite'

Ⓓ Teeth and Gum Problems

- ☐ Clenching, grinding at night (bruxism)
- ☐ Looseness and or soreness of back teeth
- ☐ Tooth pain (toothache)

Ⓔ Jaw and Jaw Joint (TMJ) Problems

- ☐ Clicking, popping jaw joints
- ☐ Grating sounds (crepitus)
- ☐ Jaw locking opened or closed
- ☐ Pain in cheek muscles
- ☐ Uncontrollable jaw, tongue movements

Ⓕ Neck and Shoulder Problems

- ☐ Lack of mobility – reduced range of movement
- ☐ Neck pain and/or stiffness
- ☐ Tired, sore, neck muscles
- ☐ Shoulder aches
- ☐ Back pain (upper and lower)
- ☐ Arm and finger tingling, numbness/pain

Ⓖ Throat Problems

- ☐ Swallowing difficulties
- ☐ Tightness of throat
- ☐ Sore throat without infection
- ☐ Frequent coughing or constant clearing of throat
- ☐ Feeling of foreign object in throat
- ☐ Tongue pain

Ⓗ Ear Pain, Ear Problems, and Loss of Balance

- ☐ Hissing, buzzing or ringing (tinnitus)
- ☐ Diminished hearing (subjective hearing loss)
- ☐ Ear pain without infection (otalgia)
- ☐ Clogged, stuffy, 'itchy' ears, feeling of fullness
- ☐ Balance problems, 'vertigo' (disequilibrium)

Tick most severe group of symptoms:

☐A ☐B ☐C ☐D ☐E ☐F ☐G ☐H

Indicate your three (3) main complaints:

.....

.....

.....

When did these symptoms first become apparent:

When are the symptoms worse:

.....

Triggered by:

Which health practitioners have you consulted:

.....

.....

PATIENT USE ONLY

TMJBDS® SLEEP QUESTIONNAIRE

Please answer the following questions on your average sleep habits/quality during the past month.

Going to sleep		**YES**	**NO**	Unsure
Do you have any problems going to bed or falling asleep?		☐	☐	☐
Do you have an irregular bedtime?		☐	☐	☐
Do you have an irregular wake time?		☐	☐	☐
Does your bedtime/wake time differ greatly between weekdays and weekends?		☐	☐	☐
While sleeping		**YES**	**NO**	Unsure
Do you often wake up at night after falling asleep?		☐	☐	☐
Do you snore while sleeping?		☐	☐	☐
Please answer these → additional questions if you answered **'Yes'** to the question above.	Do you snore on most nights (more than three nights per week)?	☐	☐	☐
	Do you snore for more than half of the night's sleep duration?	☐	☐	☐
	Do you snore loudly?	☐	☐	☐
Do you have heavy, loud breathing habits while sleeping?		☐	☐	☐
Do you have your mouth open while sleeping?		☐	☐	☐
Do you have difficulty breathing at night while sleeping?		☐	☐	☐
Has it been reported that you stop breathing or gasp during sleeping?		☐	☐	☐
Do you have regular nightmares, sleep walking or other unusual sleep behaviours?		☐	☐	☐
Do you think you are not getting enough sleep?		☐	☐	☐
Have you ever had a sleep study (PSG or Portable take home study)?		☐	☐	☐
While awake		**YES**	**NO**	Unsure
Do you feel overtired or sleepy during the day?		☐	☐	☐
Do you wake up feeling unrefreshed in the morning?		☐	☐	☐
Do you find it difficult to wake up in the morning?		☐	☐	☐
Do you wake up with headaches in the morning?		☐	☐	☐
Do you take excessive naps during the day?		☐	☐	☐
Do you tend to breathe through the mouth while awake?		☐	☐	☐
Do you have a dry mouth when you wake up in the morning?		☐	☐	☐
Do you occasionally fall asleep during the day...	... when you are busy or active?	☐	☐	☐
	... when you are driving or stopped at a traffic light?	☐	☐	☐
	... when you are sitting and talking to someone?	☐	☐	☐
	... when you are sitting or inactive in a public place?	☐	☐	☐
Have you been previously or currently treated for high blood pressure?		☐	☐	☐
Are you overweight?		☐	☐	☐

Date:	Name:	Age:	D.O.B (DD/MM/YYYY):
Address:		Postcode:	Mobile Number:
Occupation:		Health Fund:	
Referred by:		Payment Method:	

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