TMD SCREENING EXAM

Patient's Name ______________________ Date ____________

[Key: 0=None, 1=Mild, 2=Moderate, 3=Severe]

RANGE OF MOTION: **With Pain?**

			With Pain?
Maximum opening range of motion	_____	mm	R L
Right lateral movement	_____	mm	R L
Left lateral movement	_____	mm	R L
End Point Deflection on opening?	No R L		

JOINT TENDERNESS:

	R	L
Lateral palpation, mouth closed	0 1 2 3	0 1 2 3
Lateral palpation, mouth open	0 1 2 3	0 1 2 3
Palpation through auditory canal	0 1 2 3	0 1 2 3

JOINT SOUNDS:

	R	L	
Click/ Pop (degree of opening)	0 1 2 3	0 1 2 3	(Fingers)
Soft Tissue Crepitation	Y N	Y N	
Hard Tissue Grating	Y N	Y N	

MUSCLE TENDERNESS:

	R	L
Temporalis (anterior)	0 1 2 3	0 1 2 3
Deep Masseter	0 1 2 3	0 1 2 3
Superficial Masseter	0 1 2 3	0 1 2 3

OCCLUSAL FINDINGS:

	R	L	Division
Angle's Classification	1 2 3	1 2 3	I II

Occlusal wear **Posterior** 0 1 2 3 **Anterior** 0 1 2 3

Anterior tooth fremitus No ___ ___ ___ ___ ___ ___

Overbite _____ mm **Overjet** _____ mm **Crossbite** Ant R L

☐ **Chin Scar** ☐ **History of Facial Trauma**

FACIAL SYMMETRY:

Evaluate midline symmetry and alignment of face, jaws and dental arches.

Significant findings: ______________________________

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Other pertinent findings or patient comments: ______________

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TMD SCREENING QUESTIONNAIRE

Patient's Name ______________________ Date ____________

Patient's Age ________ Gender ☐ M ☐ F

1. **Y** **N** Do you have frequent pain in or near your ears, in your temples, your cheeks or jaw joints? [ ] Right [ ] Left
2. **Y** **N** Do you have any pain or difficulty getting your mouth open widely [ ] on awakening [ ]or when yawning?
3. **Y** **N** Do you have pain, stiffness, or fatigue in your jaw from chewing, talking, or at dental visits?
4. **Y** **N** Do you have frequent [ ]headaches [ ]or neckaches?
5. **Y** **N** Do you have headaches upon awakening?
6. **Y** **N** Does your jaw ever get "stuck," catch, lock or "go out" [ ]on opening? [ ] with chewing [ ] or with yawning?
7. **Y** **N** Has catching or locking occurred at any time in the past?
8. **Y** **N** Do you currently have sounds in either jaw joint, such as [ ]clicking or popping, [ ] grating or grinding? [ ] Right joint? [ ] Left joint?
9. **Y** **N** If your jaw joints do not currently make any sounds, have they at any time in the past? [ ] Right [ ] Left
10. **Y** **N** Have you ever had trauma to your head, face, or jaw?
11. **Y** **N** Are you aware or do you suspect that you [ ]clench [ ] or grind your teeth?
12. **Y** **N** Does your bite feel strained or uncomfortable?
13. **Y** **N** Do your back teeth contact more heavily on one side? [ ] Right [ ] Left
14. **Y** **N** Do your front teeth contact more heavily than the back?
15. **Y** **N** Have you noticed a recent change in your bite?
16. **Y** **N** Do you [ ] habitually chew on [ ] or accidentally bite your lips, cheeks, or tongue?

Describe any other pain of the head or neck area that occurs on a regular basis. ______________________________

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Patient's Signature ______________________________