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TMJ/TMJD Health and Sleep Screening Questionnaire

Name _____ Date _____

Do you hear a click or pop in the jaw joint?		No	Yes
If so, do you have pain with the pop?	n/a	No	Yes
Does it hurt to open wide or move your jaw forward?		No	Yes
Does your jaw get sore holding open for dental appointments?		No	Yes
Are your jaws sore when you wake up?		No	Yes
Are your teeth sore when you wake up?		No	Yes
Do you clench your teeth during the day?		No	Yes
Are you aware (has a sleeping partner said) that you clench/grind at night?		No	Yes
Does your jaw get tired after chewing?		No	Yes
Do you avoid eating any foods because it makes your jaw sore?		No	Yes
Do you get headaches?		No	Yes
Do you get migraine headaches?		No	Yes
Do you get tension headaches?		No	Yes
Do you have neck muscle aches?		No	Yes
Do you have shoulder or back pains?		No	Yes
Have your wisdom teeth been removed?		No	Yes
Have you had trauma to the jaw?		No	Yes
Have you had a whiplash neck injury?		No	Yes
Do you have any ear pain?		No	Yes
Do you have ringing, buzzing, or hissing sounds in the ear?		No	Yes
Do you have trouble sleeping soundly?		No	Yes
Do you snore?		No	Yes
Have you been diagnosed with sleep apnea?		No	Yes
Have you had a sleep study?		No	Yes
If so how long ago?	n/a	No	Yes
Do you have chronic congestion or trouble breathing through your nose?		No	Yes

