



**iCare Diagnostic Imaging, LLC**  
 2781 Freeway Blvd  
 Suite 160  
 Brooklyn Center, MN 55430

**TEMPOROMANDIBULAR JOINT  
 MRI QUESTIONNAIRE**

PATIENT WEIGHT \_\_\_\_\_ PATIENT HEIGHT \_\_\_\_\_

Please indicate below where pain is located.

**INJURY/TRAUMA**

Work-related Injury \_\_\_\_\_ Yes \_\_\_\_\_

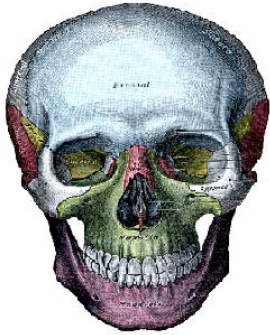
No

Motor Vehicle Accident \_\_\_\_\_ Yes \_\_\_\_\_ No

Sports Injury \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of Injury \_\_\_\_\_

Describe Injury \_\_\_\_\_



**SYMPTOMS**

\_\_\_\_\_ Headache: Acute \_\_\_\_\_ Chronic \_\_\_\_\_ Frequency/Duration \_\_\_\_\_

\_\_\_\_\_ Jaw Pain (if yes, which side?) \_\_\_\_\_

\_\_\_\_\_ Do you have noise in your jaw joint? \_\_\_\_\_

Sounds: \_\_\_\_\_ Clicking \_\_\_\_\_ Crunching \_\_\_\_\_ Popping \_\_\_\_\_

\_\_\_\_\_ Has your jaw ever locked open or closed? \_\_\_\_\_

\_\_\_\_\_ Do you clench or grind your teeth? \_\_\_\_\_

\_\_\_\_\_ Sinusitis \_\_\_\_\_

\_\_\_\_\_ Dental Surgery \_\_\_\_\_

\_\_\_\_\_ Teeth Misaligned \_\_\_\_\_

\_\_\_\_\_ Vomiting \_\_\_\_\_

\_\_\_\_\_ Seizures (etiology unknown) \_\_\_\_\_

\_\_\_\_\_ Speech difficulty \_\_\_\_\_

\_\_\_\_\_ Eye muscle weakness \_\_\_\_\_

\_\_\_\_\_ Hearing loss, clogged or muffled ears \_\_\_\_\_

\_\_\_\_\_ Numbness/tingling sensations \_\_\_\_\_

\_\_\_\_\_ How long have you had the above symptoms? \_\_\_\_\_

\_\_\_\_\_ History of medical disease (Parkinson's Disease, Arthritis, etc.)

Please describe \_\_\_\_\_

\_\_\_\_\_ History of cancer (please indicate primary cancer)

Please describe \_\_\_\_\_

**PREVIOUS STUDIES PERTAINING TO CURRENT PROBLEM**

X-Rays Yes No Where \_\_\_\_\_ Date \_\_\_\_\_

CT Scan Yes No Where \_\_\_\_\_ Date \_\_\_\_\_

MRI Scan Yes No Where \_\_\_\_\_ Date \_\_\_\_\_

Surgery/Arthroscopy

Yes No Where \_\_\_\_\_ Date \_\_\_\_\_

What was done? (please specify) \_\_\_\_\_

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**Technologist Use:** Technologist \_\_\_\_\_ Date \_\_\_\_\_  
 Contrast: \_\_\_\_\_ cc of \_\_\_\_\_ (type) injected into \_\_\_\_\_ (area).

**Notes/Complications**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_