Clinical Findings and Pain Symptoms as Potential Risk Factors for Chronic TMJD: Descriptive Data and Empirically Identified Domains from the OPPERA Case-Control Study

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Appendix A. OPPERA instruments:

self-administered questionnaires and examiner data collection instruments

Date filled out (mm-dd-yyyy)

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APM OPPERA

RESPONDENT ID LABEL

Site Examiner/Technician: Prior to the RDC/TMJD Exam, please complete the following measurements.

1. Participant's height ☐☐ Feet ☐☐ Inches
2. Participant's weight ☐☐☐ . ☐☐ lbs
3. Participant's blood pressure ☐☐☐ SBP ☐☐☐ DBP
4. Please make a photocopy of the participant's right and left hands.

	Right Hand Measurement #1	Right Hand Measurement #2
A.		
Index finger	☐☐ . ☐☐ mm	☐☐ . ☐☐ mm
Ring finger	☐☐ . ☐☐ mm	☐☐ . ☐☐ mm
	Left Hand Measurement #1	**Left Hand Measurement #2**
B.		
Index finger	☐☐ . ☐☐ mm	☐☐ . ☐☐ mm
Ring finger	☐☐ . ☐☐ mm	☐☐ . ☐☐ mm

Date filled out (mm-dd-yyyy)

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CPSQ OPPERA

RESPONDENT ID LABEL

The following questions are about pain and other symptoms in your face. For our purposes, the face refers to your temples, cheeks, jaw muscles, ears, or jaw joints. Jaw joints means the part of your jaw in front of your ear that moves when you open and close your mouth.

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

1. **In the last month,** have you had any of the symptoms listed below in your face or jaw?

	Yes	No
A. Stiffness or tightness	☐	☐
B. Cramping	☐	☐
C. Fatigue	☐	☐
D. Pressure	☐	☐
E. Soreness or tenderness	☐	☐
F. Ache, or dull ache	☐	☐

2. Have you ever had pain in your face, jaw, temple, in front of the ear, or in the ear, not including toothache or ear infection? Yes ☐ No ☐ → IF "NO" SKIP TO 16

   A. How many years or months ago did your **facial** pain begin? YEARS __ __ MONTHS __ __

3. How would you describe the duration of your **facial** pain (e.g., how long you have had your pain)?
   - ☐ Persistent -- continuous pain since initial onset
   - ☐ Recurrent -- more than one bout of pain, with periods of no pain
   - ☐ One-time -- a prior episode of pain that has ended

4. Have you ever gone to a physician, dentist, chiropractor, or other health professional for a **facial** ache or pain? Yes ☐ No ☐ → IF "NO" SKIP TO 5

   A. How long ago was your most recent visit for **facial** ache or pain?
   ☐ Within 1 to 6 months ☐ More than 6 months ago ☐ Don't Know

5. Have you had this facial ache or pain **in the last month**? Yes ☐ No ☐ → IF "NO" SKIP TO 9

6. In the last month, on the average, how often did you have pain in the face or jaw?
   ☐ Rarely ☐ Less than half the days ☐ Half or more than half the days but not daily ☐ Daily

7. In the last month, on the average, how long did each episode of pain in your face or jaw last?
   ☐ Less than 1 minute ☐ 1 minute to 1 day ☐ More than 1 day to 1 week ☐ More than 1 week but not constant ☐ Constant

8. In the last month, did any of the following activities change your face or jaw muscle pain? Please mark (☒) one response for each activity.

	Pain got worse	Pain did not change	Pain improved
A. Opening your mouth or moving your jaw forward or to the side	☐	☐	☐
B. Chewing hard or tough food	☐	☐	☐
C. Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum	☐	☐	☐
D. Resting the jaw	☐	☐	☐
E. Other jaw activities such as talking, kissing, or yawning	☐	☐	☐

For the next three questions, please rate on a scale from 0 to 10, where 0 is "No pain" and 10 is "Pain as bad as it could be".

	No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
9. How would you rate your **facial** pain at the present time, that is **right now**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. **In the past 6 months**, how intense was your worst facial pain?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. In the past 6 months, on the average, how intense was your facial pain?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

12. Approximately how many days **in the past 6 months** have you been kept from your usual activities (work, school, or housework) because of **facial** pain? If every day, please write in 180. ___ # of days

A. In the past 6 months, how many days has your efficiency dropped below 50% of what you consider "normal" for you because of **facial** pain? If every day, please write in 180. ___ # of days

For the next three questions, please rate on a scale from 0 to 10, where 0 is "No interference" and 10 is "Unable to carry on any activities". In the past 6 months, how much has your **facial** pain interfered with your:

	No interference 0	1	2	3	4	5	6	7	8	9	Unable to carry on any activities 10
13. daily activities?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. ability to take part in recreational, social and family activities?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. ability to work (including housework)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Yes	No
16. Have you been told, or do you notice, that you grind your teeth or clench your jaw while sleeping at night?	☐	☐
A. Does your jaw ache or feel stiff when you wake in the morning?	☐	☐

17. **In the last month**, did you have any of the following jaw joint noises on the **left side** of your face when you moved your jaw?

Left jaw joint:	Yes	No
A. Clicking, popping, or snapping noises	☐	☐
B. Crunching or grating noises	☐	☐
C. Other noises	☐	☐

If you selected no noises at all for your left jaw joint, skip to question 18.

	Yes	No
D. In the last month, when you had **left** jaw joint noises, did pain occur with the joint noise?	☐	☐

18. In the last month, did you have any of the following jaw joint noises on the **right side** of your face when you moved your jaw?

Right jaw joint:	Yes	No
A. Clicking, popping, or snapping noises	☐	☐
B. Crunching or grating noises	☐	☐
C. Other noises	☐	☐

If you selected no noises at all for your right jaw joint, skip to question 19.

	Yes	No
D. In the last month, when you had **right** jaw joint noises, did pain occur with the joint noise?	☐	☐

19. **Prior to a month ago**, did you have any of the following jaw joint noises in either or both of your jaw joints when you moved your jaw?

	Yes	No
A. Clicking, popping, or snapping noises	☐	☐
B. Crunching or grating noises	☐	☐
C. Other noises	☐	☐

	Yes	No
20. **In the last month**, did you avoid opening your mouth wide because of **pain**?	☐	☐
21. In the last month, regardless of pain, was there a time when you could **not** open your mouth wide even for a moment?	☐	☐

If answered **"No"** to question 21 skip to question 24.

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

22. In the last month, what was the longest amount of time that you could **not** open your mouth wide? Please mark (☒) only one response.
- ☐ Seconds to a minute
- ☐ Minutes to an hour
- ☐ Hours to a day
- ☐ Days to a week
- ☐ Longer than a week but not constant
- ☐ Constant

	Yes	No
23. In the last month, was the problem with opening your mouth wide due to **locking or catching** (that is, being stuck) in your jaw joint(s)?	☐	☐
24. **Prior to one month ago**, was there ever a time when you avoided opening your mouth wide because of pain?	☐	☐
25. Prior to one month ago, regardless of pain, was there a time when you could **not** open your mouth wide even for a moment?	☐	☐

If answered **"No"** to question 25 skip to question 27.

	Yes	No
26. Prior to one month ago, was the problem with opening your mouth wide due to **locking or catching** (that is, being stuck) in your jaw joint(s)?	☐	☐
27. **In the last month**, when you opened your mouth wide, did your jaw **lock or catch** even for a moment so that you **could not close it** from this wide open position?	☐	☐

If answered **"No"** to question 27 skip to question 30.

	Yes	No
28. In the last month, when your jaw locked or caught wide open, did you have to do something to get it to close including moving, pushing, or maneuvering it?	☐	☐

29. In the last month, what was the **longest** amount of time that your jaw locked or caught when you opened wide? Please mark (☒) only one response.
- ☐ Seconds to a minute
- ☐ Minutes to an hour
- ☐ Hours to a day
- ☐ Days to a week
- ☐ Longer than a week but not constant
- ☐ Constant

	Yes	No
30. **Prior to one month ago**, when you opened your mouth wide, did your jaw **lock or catch** even for a moment so that you **could not close it** from this wide open position?	☐	☐

If answered **"No"** to question 30 skip to question 32.

31. Prior to one month ago, how many times did your jaw lock or catch even for a moment so that you **could not close your mouth** from this wide open position?
- ☐ 1-2 times
- ☐ More than 2 times

	Yes	No
32. **In the last month**, when you closed your mouth all the way, was there a time when your teeth did not fit together in your usual bite?	☐	☐

33. **In your lifetime**, have you experienced any of the following? Mark (☒) all that apply.
- ☐ Widsom tooth extraction or other dental treatment
- ☐ Oral intubation (that is, general anesthesia with placement of a tube through your mouth)
- ☐ Significant bump to the jaw (including fall, blow, sports injury)
- ☐ Motor vehicle accident
- ☐ Accident resulting in whiplash
- ☐ Injury to your shoulder(s) or neck
- ☐ Other injury affecting the head. Please specify: _____
- ☐ None of the above

If you answered "none of the above" to question 33, skip to question 34.

33a. In your lifetime, did any of the preceding events cause injury to the jaw? ☐ Yes ☐ No ☐ Don't know

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

34. In your lifetime, have you been injured from either of the following. Mark (☒) all that apply.
- ☐ During yawning
- ☐ Prolonged mouth opening

35. Have you had orthodontic procedures (i.e., braces)? ☐ Yes ☐ No

36. **In the past year**, have you had any headaches? ☐ Yes ☐ No

If answered **"No"** to question 36 skip to question 42.

37. **In the last 30 days**, how many headaches of any type have you had?
☐☐☐ Number of headaches
☐ Don't know

38. **In the past year**, how many different types of headaches have you had (e.g., stress or tension-type, migraine, hunger headache, sinus headache)? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

39. **Headache #1 (most frequent headache):** Where is the pain? Please mark (☒) all that apply.
- ☐ Temple
- ☐ Forehead
- ☐ Top of head
- ☐ Back of the head
- ☐ Behind the eye or inside the head

A. What is the typical intensity of this type of headache?
☐ Mostly mild, ranging to moderate ☐ Mostly severe, at times moderate

B. Please indicate the characteristics of this type of headache. Please mark (☒) all that apply.
- ☐ Pain is on both sides of the head
- ☐ Pain is pressing or tightening
- ☐ Pain is throbbing or pulsating
- ☐ Pain made worse by routine physical activity such as walking or climbing stairs
- ☐ Mild nausea or sick to stomach
- ☐ Moderate or severe nausea or sick to stomach
- ☐ Vomiting
- ☐ Light is more bothersome than usual
- ☐ Sound is more bothersome than usual

C. How many years have you had this type of headache?
☐☐ years

D. In the past year, how many months have you had this type of headache?
☐☐ months

E. In the past year, on average, how many **days per month** have you had this type of headache?
- ☐ Less than 1 day per month
- ☐ 1 day or more, but less than 15 days per month
- ☐ 15 days or more per month

F. In the past year, how many **episodes** of this type of headache have you had? ☐ Less than 10 episodes ☐ 10 or more episodes

G. On average, how long does a single episode of this type of headache last?
- ☐ Less than 30 minutes per episode
- ☐ 30 minutes to less than 2 hours per episode
- ☐ 2 hours to 7 days per episode
- ☐ More than 7 days to continuous pain per episode

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

39. **Headache #1 (most frequent headache):**

H. Do any of the following activities change this type of headache? Please mark (☒) one response for each activity.

	Pain got worse	Pain did not change	Pain improved
1. Opening your mouth or moving your jaw forward or to the side.	☐	☐	☐
2. Chewing hard or tough food.	☐	☐	☐
3. Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum.	☐	☐	☐
4. Resting the jaw.	☐	☐	☐
5. Other jaw activities such as talking, kissing, or yawning.	☐	☐	☐

If no second headache, skip to question 42.

40. **Headache #2 (second most frequent headache):** Where is the pain? Please mark (☒) all that apply.

- ☐ Temple
- ☐ Forehead
- ☐ Top of head
- ☐ Back of the head
- ☐ Behind the eye or inside the head

A. What is the typical intensity of this type of headache?
- ☐ Mostly mild, ranging to moderate
- ☐ Mostly severe, at times moderate

B. Please indicate the characteristics of this type of headache. Please mark(☒) all that apply.
- ☐ Pain is on both sides of the head
- ☐ Pain is pressing or tightening
- ☐ Pain is throbbing or pulsating
- ☐ Pain made worse by routine physical activity such as walking or climbing stairs
- ☐ Mild nausea or sick to stomach
- ☐ Moderate or severe nausea or sick to stomach
- ☐ Vomiting
- ☐ Light is more bothersome than usual
- ☐ Sound is more bothersome than usual

C. How many years have you had this type of headache?
☐☐ years

D. **In the past year**, how many months have you had this type of headache?
☐☐ months

E. In the past year, on average, how many **days per month** have you had this type of headache?
- ☐ Less than 1 day per month
- ☐ 1 day or more, but less than 15 days per month
- ☐ 15 days or more per month

F. In the past year, how many **episodes** of this type of headache have you had?
- ☐ Less than 10 episodes
- ☐ 10 or more episodes

G. On average, how long does a single episode of this type of headache last?
- ☐ Less than 30 minutes per episode
- ☐ 30 minutes to less than 2 hours per episode
- ☐ 2 hours to 7 days per episode
- ☐ More than 7 days to continuous pain per episode

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

40. **Headache #2 (second most frequent headache):**

H. Do any of the following activities change this type of headache? Please mark (☒) one response for each activity.

	Pain got worse	Pain did not change	Pain improved
1. Opening your mouth or moving your jaw forward or to the side.	☐	☐	☐
2. Chewing hard or tough food.	☐	☐	☐
3. Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum.	☐	☐	☐
4. Resting the jaw.	☐	☐	☐
5. Other jaw activities such as talking, kissing, or yawning.	☐	☐	☐

If no third headache, skip to question 42.

41. **Headache #3 (third most frequent headache):** Where is the pain? Please mark (☒) all that apply.

- ☐ Temple
- ☐ Forehead
- ☐ Top of head
- ☐ Back of the head
- ☐ Behind the eye or inside the head

A. What is the typical intensity of this type of headache?
- ☐ Mostly mild, ranging to moderate
- ☐ Mostly severe, at times moderate

B. Please indicate the characteristics of this type of headache. Please mark (☒) all that apply.
- ☐ Pain is on both sides of the head
- ☐ Pain is pressing or tightening
- ☐ Pain is throbbing or pulsating
- ☐ Pain made worse by routine physical activity such as walking or climbing stairs
- ☐ Mild nausea or sick to stomach
- ☐ Moderate or severe nausea or sick to stomach
- ☐ Vomiting
- ☐ Light is more bothersome than usual
- ☐ Sound is more bothersome than usual

C. How many years have you had this type of headache?
- ☐☐ years

D. **In the past year**, how many months have you had this type of headache?
- ☐☐ months

E. In the past year, on average, how many **days per month** have you had this type of headache?
- ☐ Less than 1 day per month
- ☐ 1 day or more, but less than 15 days per month
- ☐ 15 days or more per month

F. In the past year, how many **episodes** of this type of headache have you had?
- ☐ Less than 10 episodes
- ☐ 10 or more episodes

G. On average, how long does a single episode of this type of headache last?
- ☐ Less than 30 minutes per episode
- ☐ 30 minutes to less than 2 hours per episode
- ☐ 2 hours to 7 days per episode
- ☐ More than 7 days to continuous pain per episode

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

41. **Headache #3 (third most frequent headache):**

H. Do any of the following activities change this type of headache? Please mark (☒) one response for each activity.

	Pain got worse	Pain did not change	Pain improved
1. Opening your mouth or moving your jaw forward or to the side.	☐	☐	☐
2. Chewing hard or tough food.	☐	☐	☐
3. Jaw habits such as holding teeth together, clenching/grinding teeth, or chewing gum.	☐	☐	☐
4. Resting the jaw.	☐	☐	☐
5. Other jaw activities such as talking, kissing, or yawning.	☐	☐	☐

42. We are interested in other pains that lasted a whole day or more, or that occurred several times a year due to any cause, and which you still experience. Please do not report aches and pains that are fleeting or minor such as a brief headache or sore muscles after exercising. Do you have a **persistent or chronic pain** in areas **other** than the face?

Yes ☐ **No** ☐

If answered **"No"** to question 42 skip to question 50.

For the next three questions, please rate on a scale from 0 to 10, where 0 is "No pain" and 10 is "Pain as bad as it could be".	No Pain 0	1	2	3	4	5	6	7	8	9	Pain as bad as it could be 10
43. How would you rate your **other** pain at the present time, that is **right now**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
44. **In the past 6 months**, how intense was your **worst other pain**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
45. In the past 6 months, on the average, how intense was your **other** pain?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

46. Approximately how many days in the past 6 months have you been kept from your usual activities (work, school, or housework) because of your other pain? If every day please write in 180. ☐☐☐ # of days

For the next three questions, please rate on a scale from 0 to 10, where 0 is "No interference" and 10 is "Unable to carry on any activities." In the past 6 months, how much has your **other** pain interfered with your:	No interference 0	1	2	3	4	5	6	7	8	9	Unable to carry on any activities 10
47. daily activities?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
48. ability to take part in recreational, social and family activities?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
49. ability to work (including housework)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

50. Do you have any of the following conditions or symptoms?

		Yes	No
A.	Joint disease, arthritis	☐	☐
B.	Fibromyalgia	☐	☐
C.	Chronic Fatigue Syndrome	☐	☐
D.	Irritable Bowel Syndrome	☐	☐
E.	A tendency to faint	☐	☐
F.	Ringing in your ears	☐	☐
G.	Periodic heart racing or pounding	☐	☐
H.	Repeated trouble with neck, back, or spine	☐	☐
I.	Insomnia	☐	☐
J.	Depression	☐	☐
K.	Panic Disorder	☐	☐
L.	Post-Traumatic Stress Disorder (PTSD)	☐	☐
M.	Anxiety Disorder	☐	☐
N.	Acid Reflux	☐	☐
O.	Interstitial Cystitis	☐	☐
P.	Prostatitis	☐	☐
Q.	Multiple Chemical Sensitivity	☐	☐
R.	Dysmenorrhea	☐	☐
S.	Chronic Pelvic Pain	☐	☐
T.	Sleep Apnea	☐	☐
U.	Other (describe):	☐	☐

51. Have you ever experienced pain in your lower back? ☐ Yes ☐ No

If answered **"No"** to question 51 skip to question 52.

		Yes	No			
A.	Do you currently have low back pain?	☐	☐			
B.	Has your low back pain been constant or does it come and go?	☐ Constant	☐ Comes and goes			
C.	How many episodes of low back pain have you had in the **past 12 months?**	☐ 0	☐ 1	☐ 2 - 4	☐ 5 - 10	☐ 11 or more
D.	On average, how long does each episode of low back pain last?	☐ Less than 30 minutes				
		☐ 30 minutes to less than 2 hours				
		☐ 2 hours to 7 days				
		☐ More than 7 days of continuous pain				
		Yes	No			
E.	Has your low back pain ever been accompanied by pain going down into your buttocks, upper leg or lower leg?	☐	☐			

If answered **"No"** to question 51E skip to question 51G.

F.	In which area(s) did the low back pain travel to? Mark (☒) all that apply.	☐ Buttocks	☐ Upper leg(s)	☐ Lower leg(s)

		Yes	No
G.	Have you ever had surgery for low back pain?	☐	☐

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless instructed to do so. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

		Yes	No, or rarely
52.	**In the past 3 months**, did you have discomfort or pain in your abdomen that was present during at least 3 weeks (lasting at least one day each week)? (For women, do **not** consider abdominal discomfort or pain related to your menstrual cycle or period.)	☐	☐

If answered **"No"** to question 52 skip to question 53.

		Yes	No
A.	Does your discomfort or pain get better or stop after you have a bowel movement?	☐	☐
B.	When the discomfort or pain starts, do you have a change in your usual number of bowel movements (either more or fewer)?	☐	☐
C.	When the discomfort or pain starts, do you have either softer or harder stools than usual?	☐	☐

53. Would you say that you have had any of the following at least one quarter of the time over the past three months?

		Yes	No
A.	Fewer than three bowel movements a week (0-2)	☐	☐
B.	More than three bowel movements a day (4 or more)	☐	☐
C.	Hard or lumpy stools	☐	☐
D.	Loose, mushy or watery stools	☐	☐
E.	Straining during a bowel movement	☐	☐
F.	Having to rush to the toilet to have a bowel movement	☐	☐
G.	Feeling of incomplete emptying after a bowel movement	☐	☐
H.	Passing mucus (slime) during a bowel movement	☐	☐
I.	Abdominal fullness, bloating or swelling	☐	☐
J.	Alternation between hard/lumpy and loose/watery stools	☐	☐

		Yes	No
54.	Have you ever experienced itching in your genital area that persisted for 3 months or longer?	☐	☐
55.	Have you ever experienced burning in your genital area that persisted for 3 months or longer?	☐	☐
56.	Have you ever experienced periodic knife-like or sharp pain in your genital area that persisted for 3 months or longer?	☐	☐
57.	Have you ever experienced excessive pain on contact to your genital area? For example, upon insertion of a tampon (if female), at the time of sexual intercourse, or during a pelvic examination.	☐	☐

Date filled out (mm-dd-yyyy)

__ __ - __ __ - __ __ __ __

JFLS OPPERA

RESPONDENT ID LABEL

For each of the items listed below, indicate the level of limitation **during the last month**. If the activity has been completely avoided because it is too difficult, then mark (☒) the "10" column. If you avoid an activity for reasons other than pain or difficulty, then mark (☒) the "NA" (Not Applicable) column.

Mark(☒) one response for each item and do not skip any items. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

		No Limitation										Severe Limitation
	NA	0	1	2	3	4	5	6	7	8	9	10
1. Chew tough food.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. Chew hard bread.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Chew chicken (e.g., prepared in oven).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Chew crackers.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Chew soft food (e.g. macaroni, canned or soft fruits, cooked vegetables, fish).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Eat soft food requiring no chewing (e.g., mashed potatoes, apple sauce, pudding, pureed food).	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7. Open wide enough to bite from a whole apple.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Open wide enough to bite into a sandwich.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Open wide enough to talk.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Open wide enough to drink from a cup.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Swallow.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Yawn.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Talk.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Sing.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Putting on a happy face.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Putting on an angry face.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17. Frown.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Kiss.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Smile.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Putting on a sad face.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21. Laugh.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date filled out (mm-dd-yyyy)

__ __ - __ __ - __ __ __ __

MEDICAL HISTORY OPPERA

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

Please answer each condition by marking (☒) the "Yes" box for any condition that you have had in the **past** or have **now**, or "No" if you have never had that condition.

	1. Cardiovascular Conditions:	**Yes**	**No**
	Mitral valve prolapse	☐	☐
	High blood pressure	☐	☐
	Angina	☐	☐
	Heart attack	☐	☐
	Heart failure	☐	☐
	Pacemaker/Defibrillator	☐	☐
	Stroke	☐	☐
	Other heart problems	☐	☐
	2. Hematologic:	**Yes**	**No**
	Anemia	☐	☐
	Hemophilia/other bleeding disorders	☐	☐
	Leukemia	☐	☐
	3. Neural & Sensory:	**Yes**	**No**
	Earaches, ringing in ears	☐	☐
	Hearing loss	☐	☐
	Severe headaches	☐	☐
	Fainting or dizzy spells	☐	☐
	Epilepsy, seizures or convulsions	☐	☐
	Psychiatric treatment	☐	☐
	4. Gastrointestinal:	**Yes**	**No**
	Stomach/intestinal ulcers	☐	☐
	Gastritis	☐	☐
	Colitis	☐	☐
	Persistent diarrhea	☐	☐
	Hepatitis	☐	☐
	5. Endocrine:	**Yes**	**No**
	Diabetes	☐	☐
	Hypothyroid disease	☐	☐
	Hyperthyroid disease	☐	☐
	6. Respiratory:	**Yes**	**No**
	Sinus trouble	☐	☐
	Allergies or hives	☐	☐
	Asthma	☐	☐
	Tuberculosis (TB)	☐	☐
	Breathing difficulties	☐	☐
	Sleep apnea	☐	☐
	7. Dermal Mucocutaneous Musculoskeletal:	**Yes**	**No**
	Allergy to latex (rubber)	☐	☐
	Skin rashes	☐	☐
	Night sweats	☐	☐
	Muscle problems	☐	☐
	Fibromyalgia/Chronic Fatigue Syndrome	☐	☐
	Osteoarthritis	☐	☐
	Rheumatoid Arthritis	☐	☐
	Sjogren's Syndrome	☐	☐

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

Please answer each condition by marking (☒) the "Yes" box for any condition that you have had in the **past** or have **now**, or "No" if you have never had that condition.

8. Urinary-Sexually Transmitted:	Yes	No
Sexually transmitted disease (syphilis, gonorrhea, chlamydia, or genital herpes)	☐	☐
HIV positive	☐	☐
AIDS	☐	☐

9. Other Conditions:	Yes	No
Use alcohol	☐	☐
Drug/alcohol addiction (current/recovering)	☐	☐
Tumor or cancer	☐	☐
Chemotherapy	☐	☐
Radiation therapy	☐	☐

	Yes	No
10. Obstructive Sleep / Breathing Problems:	☐	☐

11. Disease, problem or condition not listed	Yes	No
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

12. Medications: taken in the past	Yes	No
Antihistamines	☐	☐
Aspirin/other pain medications	☐	☐
Corticosteroids	☐	☐
Dilantin	☐	☐
Insulin, tolbutamide/drugs to control blood sugar	☐	☐
Anticoagulants (blood thinners)	☐	☐
Anti-hypertensives (blood pressure medications)	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerine	☐	☐
Tranquilizers	☐	☐
Antidepressants	☐	☐

13. Medications being taken now (Include herbal and over the counter medications): Please list one per line.

_____

_____

_____

_____

_____

_____

_____

_____

RESPONDENT ID LABEL

Mark(☒) one response for each item and do not skip any items unless otherwise specified. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

14. Have you smoked at least 100 cigarettes in your entire life?
- ☐ Yes
- ☐ No → IF "NO" SKIP TO 18
- ☐ Don't Know / Not Sure

15. Previously you said you have smoked cigarettes. How old were you the first time you smoked a cigarette, even one or two puffs?
☐☐ Enter age in years

16. Do you now smoke cigarettes everyday, some days, or not at all?
☐ Everyday ☐ Some days ☐ Not at all

17. How old were you when you first started smoking cigarettes regularly?
If never smoked regularly, enter 88.
☐☐ Enter age in years

18. How do you describe your health overall?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

19. Have you been hospitalized for any surgical operation or serious illness?
If yes, please describe.
Yes ☐ No ☐

FOR OFFICE USE ONLY

20. Examiner Comments:

Date filled out (mm-dd-yyyy)

__ __ - __ __ - __ __ __ __

OBC OPPERA

RESPONDENT ID LABEL

How often do you do each of the following activities, based on **the last month**? If the frequency of the activity varies, choose the higher option.

Mark(☒) one response for each item and do not skip any items. If you change your mind, fill the incorrect mark completely and then mark (☒) the new response.

Activities During Sleep	None of the time	< 1 Night / Month	1-3 Nights / Month	1-3 Nights / Week	4-7 Nights / Week
1. Clench or grind teeth **when asleep**, based on any information you may have.	☐	☐	☐	☐	☐
2. Sleep in a position that puts pressure on the jaw (for example, on stomach, on the side).	☐	☐	☐	☐	☐

Activities During Waking Hours	None of the time	A little of the time	Some of the time	Most of the time	All of the time
3. Grind teeth together **during waking hours.**	☐	☐	☐	☐	☐
4. Clench teeth together **during waking hours.**	☐	☐	☐	☐	☐
5. Press, touch, or hold teeth together other than while eating (that is, contact between upper and lower teeth).	☐	☐	☐	☐	☐
6. Hold, tighten, or tense muscles without clenching or bringing teeth together.	☐	☐	☐	☐	☐
7. Hold or jut jaw forward or to the side.	☐	☐	☐	☐	☐
8. Press tongue forcibly against teeth.	☐	☐	☐	☐	☐
9. Place tongue between teeth.	☐	☐	☐	☐	☐
10. Bite, chew, or play with your tongue, cheeks or lips.	☐	☐	☐	☐	☐
11. Hold jaw in rigid or tense position, such as to brace or protect the jaw.	☐	☐	☐	☐	☐
12. Hold between the teeth or bite objects such as hair, pipe, pencil, pens, fingers, fingernails, etc.	☐	☐	☐	☐	☐
13. Use chewing gum.	☐	☐	☐	☐	☐
14. Play musical instrument that involves use of mouth or jaw (for example, woodwinds, brass, string instruments).	☐	☐	☐	☐	☐
15. Lean with your hand on the jaw, such as cupping or resting the chin in the hand.	☐	☐	☐	☐	☐
16. Chew food on one side only.	☐	☐	☐	☐	☐
17. Eating between meals (that is, food that requires chewing).	☐	☐	☐	☐	☐
18. Sustained talking (for example, teaching, sales, customer service).	☐	☐	☐	☐	☐
19. Singing.	☐	☐	☐	☐	☐
20. Yawning.	☐	☐	☐	☐	☐
21. Hold telephone between your head and shoulders.	☐	☐	☐	☐	☐

Date filled out (mm-dd-yyyy) ___ - ___ - ____

RDC TMJD EXAM OPPERA

RESPONDENT ID LABEL

Examiner ID: ____

1. Scope of this Examination
- Administer SCREENING PAIN SELF REPORT.
- Subject reads pain definition card.
- Review scope of examination.

FOR OFFICE USE ONLY
Screening Classification
(1) Potential Study 1 (2) Potential Study 2 (3) Positive QHU (4) Negative QHU (5) Recall

2. Laterality of Pain: Last month (Choose one) ◯ None ◯ Right ◯ Left ◯ Both

3. Location of Pain: Last month (Select all that apply)

RIGHT PAIN	LEFT PAIN
◯ None ◯ Temporalis ◯ Other m. muscles ◯ TMJ ◯ Neck	◯ None ◯ Temporalis ◯ Other m. muscles ◯ TMJ ◯ Neck

4. Incisal Relationships

A. Maxillary Incisor Used (Choose one) ◯ 8 ◯ 9

B. Horizontal Incisor Overjet ◯ If negative ____ mm

C. Vertical Incisor Overbite ◯ If negative ____ mm

5. Opening-Closing Pattern (Choose one) ◯ Straight ◯ Deviation ◯ Right lateral deflection ◯ Left lateral deflection

6. Vertical Range of Mandibular Motion

A. Pain Free Opening ____ mm

B. Maximum Unassisted Opening ____ mm

C. Maximum Assisted Opening ____ mm

D. Terminated? (N) (Y)

RIGHT SIDE	Pain	Familiar Pain	Familiar Headache
Temporalis	(N) (Y)	(N) (Y)	(N) (Y)
L, M, or S	(N) (Y)	(N) (Y)	Lat Pter (Y) Mass (Y) Sub Mand (Y)
TMJ	(N) (Y)	(N) (Y)	
Neck	(N) (Y)	(N) (Y)	

LEFT SIDE	Pain	Familiar Pain	Familiar Headache
Temporalis	(N) (Y)	(N) (Y)	(N) (Y)
L, M, or S	(N) (Y)	(N) (Y)	Lat Pter (Y) Mass (Y) Sub Mand (Y)
TMJ	(N) (Y)	(N) (Y)	
Neck	(N) (Y)	(N) (Y)	

7. Mandibular Excursive Movements

A. Right Lateral Excursion
◯ Cannot assess ____ mm

B. Left Lateral Excursion
◯ Cannot assess ____ mm

C. Protrusion
◯ Cannot assess ____ mm
◯ If negative

RIGHT SIDE	Pain	Familiar Pain	Familiar Headache
Temporalis	(N) (Y)	(N) (Y)	(N) (Y)
L, M, or S	(N) (Y)	(N) (Y)	Lat Pter (Y) Mass (Y) Sub Mand (Y)
TMJ	(N) (Y)	(N) (Y)	
Neck	(N) (Y)	(N) (Y)	

LEFT SIDE	Pain	Familiar Pain	Familiar Headache
Temporalis	(N) (Y)	(N) (Y)	(N) (Y)
L, M, or S	(N) (Y)	(N) (Y)	Lat Pter (Y) Mass (Y) Sub Mand (Y)
TMJ	(N) (Y)	(N) (Y)	
Neck	(N) (Y)	(N) (Y)	

RESPONDENT ID LABEL

8. TMJ Sounds on Open and Close (palpation)

RIGHT TMJ	Open	Close
A. Click	N Y	N Y
B. Crepitus	N Y	N Y

LEFT TMJ	Open	Close
A. Click	N Y	N Y
B. Crepitus	N Y	N Y

9. TMJ Sounds on Open, Close and Horizontal Movements (auscultation)

RIGHT JOINT OPEN AND CLOSE

Examiner	Subject	Pain w/ sound	Familiar Pain
A. Click N Y	D. N Y	G. N Y	H. N Y
B. Crepitus N Y	E. N Y		
C. Other	F. N Y		

LEFT JOINT OPEN AND CLOSE

Examiner	Subject	Pain w/ sound	Familiar Pain
A. Click N Y	D. N Y	G. N Y	H. N Y
B. Crepitus N Y	E. N Y		
C. Other	F. N Y		

RIGHT JOINT PROTRUSION AND CONTRALATERAL EXCURSION

Examiner	Subject	Pain w/ sound	Familiar Pain
A. Click N Y	D. N Y	G. N Y	H. N Y
B. Crepitus N Y	E. N Y		
C. Other	F. N Y		

LEFT JOINT PROTRUSION AND CONTRALATERAL EXCURSION

Examiner	Subject	Pain w/ sound	Familiar Pain
A. Click N Y	D. N Y	G. N Y	H. N Y
B. Crepitus N Y	E. N Y		
C. Other	F. N Y		

10. Palpation for Pain (2 lbs): Extraoral Masticatory Muscles

RIGHT

	Pain	Familiar Pain	Familiar Headache	RF
A. Temporalis **(Posterior)**				
Inferior	N Y	N Y	N Y	R
Middle	N Y	N Y	N Y	R
Superior	N Y	N Y	N Y	R
B. Temporalis **(Middle)**				
Inferior	N Y	N Y	N Y	R
Middle	N Y	N Y	N Y	R
Superior	N Y	N Y	N Y	R
C. Temporalis **(Anterior)**				
Inferior	N Y	N Y	N Y	R
Middle	N Y	N Y	N Y	R
Superior	N Y	N Y	N Y	R

LEFT

	Pain	Familiar Pain	Familiar Headache	RF
A. Temporalis **(Posterior)**				
Inferior	N Y	N Y	N Y	R
Middle	N Y	N Y	N Y	R
Superior	N Y	N Y	N Y	R
B. Temporalis **(Middle)**				
Inferior	N Y	N Y	N Y	R
Middle	N Y	N Y	N Y	R
Superior	N Y	N Y	N Y	R
C. Temporalis **(Anterior)**				
Inferior	N Y	N Y	N Y	R
Middle	N Y	N Y	N Y	R
Superior	N Y	N Y	N Y	R

RIGHT

	Pain	Familiar Pain	RF
D. Masseter **(Origin)**			
Posterior	N Y	N Y	R
Middle	N Y	N Y	R
Anterior	N Y	N Y	R
E. Masseter **(Body)**			
Posterior	N Y	N Y	R
Middle	N Y	N Y	R
Anterior	N Y	N Y	R
F. Masseter **(Insertion)**			
Posterior	N Y	N Y	R
Middle	N Y	N Y	R
Anterior	N Y	N Y	R

LEFT

	Pain	Familiar Pain	RF
D. Masseter **(Origin)**			
Posterior	N Y	N Y	R
Middle	N Y	N Y	R
Anterior	N Y	N Y	R
E. Masseter **(Body)**			
Posterior	N Y	N Y	R
Middle	N Y	N Y	R
Anterior	N Y	N Y	R
F. Masseter **(Insertion)**			
Posterior	N Y	N Y	R
Middle	N Y	N Y	R
Anterior	N Y	N Y	R

RESPONDENT ID LABEL

11. Palpation for Pain (2 lbs): Neck Muscles

RIGHT	Pain	Familiar Pain	RF	LEFT	Pain	Familiar Pain	RF
A. SCM				A. SCM			
Upper	N Y	N Y	R	a. Upper	N Y	N Y	R
Middle	N Y	N Y	R	b. Middle	N Y	N Y	R
Lower	N Y	N Y	R	c. Lower	N Y	N Y	R
B. Upper Splenius Capitus	N Y	N Y	R	B. Upper Splenius Capitus	N Y	N Y	R
C. Upper Semispinalis Capitus	N Y	N Y	R	C. Upper Semispinalis Capitus	N Y	N Y	R
D. Mid Splenius Capitus (C_3)	N Y	N Y	R	D. Mid Splenius Capitus (C_3)	N Y	N Y	R
E. Lower Splenius Capitus (C_5)	N Y	N Y	R	E. Lower Splenius Capitus (C_5)	N Y	N Y	R

12. Palpation for Pain (1 lb): Extraoral Masticatory Muscles

RIGHT	Pain	Familiar Pain	RF	LEFT	Pain	Familiar Pain	RF
A. Posterior Mandibular	N Y	N Y	R	A. Posterior Mandibular	N Y	N Y	R
B. Submandibular Region	N Y	N Y	R	B. Submandibular Region	N Y	N Y	R

13. Palpation for Pain (1 lb): TMJ

RIGHT	Pain	Familiar Pain	RF	LEFT	Pain	Familiar Pain	RF
A. Lateral Pole TMJ	N Y	N Y	R	A. Lateral Pole TMJ	N Y	N Y	R
B. Posterior Attachment TMJ	N Y	N Y	R	B. Posterior Attachment TMJ	N Y	N Y	R
C. Dorsal Aspect TMJ	N Y	N Y	R	C. Dorsal Aspect TMJ	N Y	N Y	R

14. Palpation for Pain (1 lb): Intraoral Masticatory Muscles

RIGHT	Pain	Familiar Pain	RF	LEFT	Pain	Familiar Pain	RF
A. Lateral Pterygoid Area	N Y	N Y	R	A. Lateral Pterygoid Area	N Y	N Y	R
B. Tendon of Temporalis	N Y	N Y	R	B. Tendon of Temporalis	N Y	N Y	R
C. Medial Masseter	N Y	N Y	R	C. Medial Masseter	N Y	N Y	R

15. Intraoral Findings

RIGHT		LEFT	
A. Cheek Ridging	N Y	A. Cheek Ridging	N Y
B. Tongue Scalloping	N Y	B. Tongue Scalloping	N Y
C. Bruxofacets	Right Lateral N Y	Left Lateral N Y	Protrusions N Y

16. Palpation for Pain (3 lbs): General Body Examination

RIGHT	Pain	Familiar Pain	RF	LEFT	Pain	Familiar Pain	RF
A. TMJ	N Y	N Y	R	A. TMJ	N Y	N Y	R
B. Trapezius	N Y	N Y	R	B. Trapezius	N Y	N Y	R
C. Supraspinatus	N Y	N Y	R	C. Supraspinatus	N Y	N Y	R
D. Second Rib	N Y	N Y	R	D. Second Rib	N Y	N Y	R
E. Lateral Epicondyle	N Y	N Y	R	E. Lateral Epicondyle	N Y	N Y	R
F. Gluteal	N Y	N Y	R	F. Gluteal	N Y	N Y	R
G. Greater Trochanter	N Y	N Y	R	G. Greater Trochanter	N Y	N Y	R
H. Knee	N Y	N Y	R	H. Knee	N Y	N Y	R

RESPONDENT ID LABEL

17. Pressure Pain Thresholds

RIGHT SIDE	Trial 1	Trial 2
A. Temporalis (anterior)		
B. Masseter (body)		
C. TMJ (lateral pole)		
D. Trapezius (mid upper border)		
E. Lateral Epicondyle		

LEFT SIDE	Trial 1	Trial 2
A. Temporalis (anterior)		
B. Masseter (body)		
C. TMJ (lateral pole)		
D. Trapezius (mid upper border)		
E. Lateral Epicondyle		

18. Physical Barrier(s) to Examination

Barriers (N) (Y)

If **YES,** specify:

19. Examination Comments

20. Research Classification (Choose one)

- ◯ Normal
- ◯ TMJD → **GO TO 20A**
- ◯ Neither Normal nor TMJD
- ◯ Uncertain

20A. TMJD Sub-Classification (complete if TMJD)

A. Myalgia (N) (Y)

B. Arthralgia (N) (Y)

21. Classification Comments