HOSKINS FAMILY & COSMETIC DENTISTY
OCCLUSAL SIGNS EXAM FORM

NAME______________________________
DATE_______________________________
AGE________________________________

SYMPTOMS: PLEASE CHECK ANY AND ALL THAT APPLY

1. ____HEADACHES
2. ____TMJ PAIN (JAW PAIN)
3. ____TMJ NOISE (JAW POPPING)
4. ____LIMITED OPENING OF MOUTH
5. ____EAR CONGESTION
6. ____VERTIGO (DIZZINESS)
7. ____TINNITUS (RINGING IN EARS)
8. ____DYSPHAGIA (DIFFICULTY SWALLOWING)
9. ____LOOSE TEETH
10. ____CLENCHING/BRUXING
11. ____FACIAL PAIN (NONSPECFIC)
12. ____TENDER, SENSITIVE TEETH (WHEN YOU BITE DOWN)
13. ____DIFFICULTY CHEWING
14. ____CERVICAL PAIN (NECK)
15. ____POSTURAL PROBLEMS (SLUMPING ETC)
16. ____PARESTHESIA OF FINGERTIPS (TINGLING)
17. ____THERMAL SENSITIVITY (HOT & COLD)
18. ____TRIGEMINAL NEURALGIA
19. ____BELLS PALSY
20. ____NERVOUSNESS/INSOMNIA
21. ___ARE YOU PLEASED WITH YOUR SMILE?
    IF NOT, WHAT WOULD YOU LIKE TO CHANGE?

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