

DR. NICHOLAS R. FRATANTONIO

MUSCULO-OCCLUSAL SIGNS AND SYMPTOMS

NAME: _____ DATE: _____

Symptoms: Please check any or all that apply to you

- | | |
|---|--|
| 1. <input type="checkbox"/> Headaches | 12. <input type="checkbox"/> Loose teeth |
| 2. <input type="checkbox"/> TMJ pain (L or R) | 13. <input type="checkbox"/> Clenching/bruxing |
| 3. <input type="checkbox"/> TMJ noise (L or R) | 14. <input type="checkbox"/> Sensitive teeth |
| 4. <input type="checkbox"/> Pain in ears (L or R) | 15. <input type="checkbox"/> Difficulty chewing |
| 5. <input type="checkbox"/> Pain around eyes (L or R) | 16. <input type="checkbox"/> Difficulty swallowing |
| 6. <input type="checkbox"/> Pain in neck | 17. <input type="checkbox"/> Limited opening |
| 7. <input type="checkbox"/> Pain in shoulders | 18. <input type="checkbox"/> Loud snoring |
| 8. <input type="checkbox"/> Pain in forehead | 19. <input type="checkbox"/> Clicking/popping in jaw |
| 9. <input type="checkbox"/> Pain in temples (L or R) | 20. <input type="checkbox"/> Ear congestion |
| 10. <input type="checkbox"/> Dizziness | 21. <input type="checkbox"/> Tingling in fingertips |
| 11. <input type="checkbox"/> Ringing in ears (L or R) | 22. <input type="checkbox"/> Upset stomach |

Signs: To be filled out by Doctor or Hygienist

- | | |
|--|---|
| 1. <input type="checkbox"/> Crowded lower anteriors | 18. <input type="checkbox"/> Loss of molars |
| 2. <input type="checkbox"/> Wear of lower anterior teeth | 19. <input type="checkbox"/> Cross bite |
| 3. <input type="checkbox"/> Lingual inclination of lower anteriors | 20. <input type="checkbox"/> Anterior open bite |
| 4. <input type="checkbox"/> Bicuspids drop off | 21. <input type="checkbox"/> Tongue thrust |
| 5. <input type="checkbox"/> Depressed curve of spee | 22. <input type="checkbox"/> Scalloping of tongue |
| 6. <input type="checkbox"/> Lingual inclination of upper anteriors | 23. <input type="checkbox"/> Gingival inflammation |
| 7. <input type="checkbox"/> Lingually tipped lower posteriors | 24. <input type="checkbox"/> Facial asymmetry |
| 8. <input type="checkbox"/> Narrow mandibular arch | 25. <input type="checkbox"/> Chelitis |
| 9. <input type="checkbox"/> Narrow maxillary arch | 26. <input type="checkbox"/> Abnormal lip posture |
| 10. <input type="checkbox"/> Midline discrepancy | 27. <input type="checkbox"/> Deep mentalis crease |
| 11. <input type="checkbox"/> Tooth mobility | 28. <input type="checkbox"/> Mandibular Torticollis |
| 12. <input type="checkbox"/> Flared upper anterior teeth | 29. <input type="checkbox"/> Cervical Torticollis |
| 13. <input type="checkbox"/> Facets | 30. <input type="checkbox"/> Forward head posture |
| 14. <input type="checkbox"/> Abfractions | 31. <input type="checkbox"/> Speech abnormalities |
| 15. <input type="checkbox"/> Locked upper buccal cusps | |
| 16. <input type="checkbox"/> Fractured cusps | |
| 17. <input type="checkbox"/> Chipped anterior teeth | |