

# Signs and Symptoms Dental Examination Checklist

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle any of the following symptoms that you may be experiencing now or have experienced in the past.

## Symptoms

1. Headaches
2. TMJ pain (Temporo-mandibular joint)
3. TMJ noise
4. Limited opening
5. Ear congestion
6. Vertigo (Dizziness)
7. Tinnitus (Ringing in the ears)
8. Dysphagia (Difficulty swallowing)
9. Loose teeth
10. Clenching/Bruxing/Grinding (Circle any that apply)
11. Facial pain (non-specific)
12. Tender, sensitive teeth
13. Difficulty chewing
14. Cervical (Neck) pain
15. Postural problems
16. Paresthesia of fingertips (Tingling)
17. Thermal sensitivity (Hot and/or cold)
18. Trigeminal neuralgia
19. Bell's Palsy
20. Nervousness/Insomnia
21. Sleep apnea