

# CLINICAL EXAMINATION FORM

**Patient Name and Surname:** .....

**Gender:**  Female  Male

**Date:** ..... / ..... / .....

**Date of Birth:** ..... / ..... / .....

**Initial Visit Date:** ..... / ..... / .....

**Chief Complaint:** .....

## **Pubertal Development / Menstrual History**

### **Pubertal Development:**

Pre-pubertal

Pubertal (signs present)

Post-pubertal

(If applicable, please specify signs: .....)

## **Extraoral Examination**

Round  Square  Oval

### **Profile:**

Straight  Convex  Concave

### **Chin Position:**

Prominent  Retruded  Normal

### **Lower Facial Height:**

Increased  Normal  Decreased

### **Nasal Form:**

Large  Normal  Small

### **Asymmetry:**

Present  Absent If present, please specify: .....

### **Perioral Muscles:**

Tight    Normal    Weak

**Masticatory Muscles:**

Tight    Normal    Weak

**Lips:**

Competent    Incompetent

Thin    Thick    Normal

Tight tone    Normal tone    Hypotonic / Loose tone

**Tongue:**

Small    Normal    Large

Restrictive (Tongue-tie)    Non-restrictive

**Orofacial Function Examination**

**Swallowing Pattern:**

Dental contact present

Mentalis muscle activity present

Tongue thrust

Normal

**Speech Assessment**

Normal    Atypical (Please explain): .....

**Breathing Pattern**

Nasal    Oral    Oro-nasal

Noisy breathing:  Yes    No

**Dental Examination:**

**Oral Hygiene**

Good    Fair    Poor

**Caries Status** (If present, please specify the affected teeth)

Present     Absent

.....

**Permanent tooth extraction** (If present, please specify the affected teeth)

Yes     No

.....

**Dentition Stage**

Primary     Mixed     Permanent

**Crowding Assessment**

Anterior crowding:  Yes     No

Posterior crowding:  Yes     No

**Angle Classification**

**Canines:**

**Right:**  CI     CII     CIII

**Left:**  CI     CII     CIII

**Molars:**

**Right:**  CI     CII     CIII

**Left:**  CI     CII     CIII

**Midline and Occlusion Examination**

**Midline on occlusion:**

Symmetric     Asymmetric ( upper / lower ..... mm left / right )

**Overjet:** ..... mm    **Overbite:** ..... mm

**Crossbite:**

**Anterior:**  Yes     No

**Posterior:**  Right     Left     Bilateral

**Arch Form:**

Normal    Narrow    Wide

**Functional Examination**

**Lateral Movements:**

Normal    Restricted

**Guidance:**  Canine    Group Function    Other: .....

**Protrusive Movement:**

Normal    Restricted

Premature contacts:  Yes    No

**Freeway Space:**

Anterior: ..... mm   Posterior: ..... mm

**Temporomandibular Joint Examination**

*(DC/TMD-based clinical screening)*

**Symptoms:**

Pain    Clicking    Crepitus    Locking    None

**Pain on Palpation:**

None    Mild    Moderate    Severe

Location:  Preauricular    Masseter    Temporalis

**Deviation:**

Present    Absent

If present → Direction:  Right    Left

**Deflection:**

Present    Absent

**Range of Motion (Interincisal Opening): ..... mm**

**Lateral movement:** Right: ..... mm    Left: ..... mm

**Protrusion:** ..... mm

**Functional Limitations:**

Pain during chewing     Fatigue     Locking history     None

**Diagnosis / Notes:**

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**Examiner Name and Signature:**

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# PARENT / GUARDIAN QUESTIONNAIRE FORM

*(To be completed by the parent or legal guardian)*

## 1. Child's General Information

**Child's Name:** .....

**Date of Birth:** ..... / ..... / .....

**Parent/Guardian Name:** .....

**Relationship to Child:**  Mother  Father  Other: .....

**Phone Number:** .....

**E-mail Address:** .....

## 2. Medical History

**Has your child ever been diagnosed with the following?**

- Asthma
- Allergies (food/environmental)
- Chronic mouth breathing
- Sleep apnea or snoring
- Cardiovascular disease
- Rheumatic fever
- Diabetes
- Anemia
- Epilepsy or seizures
- ADHD / Attention problems
- Autism spectrum disorder
- Genetic syndromes
- Frequent ear infections
- Tonsil/adenoid problems
- Gastroesophageal reflux
- Other: .....

**Current Medications:**

None

If yes, please list: .....

**Previous Surgeries:**

None

If yes, please list: .....

**Childhood illnesses:** .....

**Is the child currently receiving any medical treatment?**

Yes  No

If yes, explain: .....

**Frequent colds / upper respiratory infections:**

Yes  No

**Allergies:**

.....

**Dizziness or fainting:**

Yes  No

If yes, explain: .....

**History of trauma:**

Yes  No

If yes, explain: .....

**3. Oral Habits**

**Has your child ever had any of the following habits?**

**(Indicate both "Current" and "Past")**

<b>Habit</b>	<b>Current Past</b>	
Thumb/finger sucking	<input type="checkbox"/>	<input type="checkbox"/>
Pacifier use	<input type="checkbox"/>	<input type="checkbox"/>
Lip biting	<input type="checkbox"/>	<input type="checkbox"/>
Nail biting	<input type="checkbox"/>	<input type="checkbox"/>
Object chewing (pens, blankets, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Bruxism (teeth grinding)	<input type="checkbox"/>	<input type="checkbox"/>
Tongue thrust	<input type="checkbox"/>	<input type="checkbox"/>

<b>Habit</b>	<b>Current Past</b>	
Cheek biting	<input type="checkbox"/>	<input type="checkbox"/>
Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>
Snoring during sleep	<input type="checkbox"/>	<input type="checkbox"/>

If any are present, please describe frequency:

.....

.....

#### **4. Feeding and Early Childhood History**

**Feeding pattern during infancy:**

Breastfeeding    Bottle feeding    Both

Details: .....

**Duration:**

Breastfeeding: ..... months      Bottle feeding: ..... months

#### **6. Oral Hygiene & Dental History**

**Tooth brushing attention:**

Yes    No

**Brushing frequency:**

Once daily    Twice daily    Irregular

**Previous orthodontic treatment:**

Yes    No

If yes, explain: .....

**Trauma to teeth or jaws:**

Yes    No

If yes, explain: .....

**7. Behavior and Learning**

**Is the child calm and compliant at home?**

Yes    No

Comments: .....

**Child's learning capacity:**

Age-appropriate    Needs support    Other: .....

**8. Family History**

**Family history of craniofacial characteristics:**

Yes    No

If yes, specify (e.g., retrognathic or prognathic mandible, facial asymmetry):

.....

**9. Parent's Thoughts / Concerns / Recommendations**

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.....  
.....  
.....

**Parent/Guardian Signature:**

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