

Clinical Evaluation (Head and Neck Exam)

Patient Name: _____ Male: Female: DOB: ___/___/___

Doctor: _____ Exam Date: ___/___/___

Chief Complaint:

Vitals:







B/P: ___/___ Height: ___' ___" Weight ___ lbs. BMI ___ Pulse ___ bpm Neck Circum. ___

Atypical Facial Pain (History) Headaches (History) Tinnitus (History)
 Clenching Nocturnal Bruxism

Extraoral Exam					
Head & Face			Craniofacial Muscles		Neck/Thyroid
Brachyfacial (Short) <input type="checkbox"/>	Facial Lesions <input type="checkbox"/>		Masseter Hypertrophy <input type="checkbox"/>		Enlarged Thyroid (Palpable) <input type="checkbox"/>
Dolichofacial (Long) <input type="checkbox"/>	Lower Scleral Show <input type="checkbox"/>				Enlarged Lymph Nodes <input type="checkbox"/>
Facial Asymmetry <input type="checkbox"/>	Periorbital Venous Pooling <input type="checkbox"/>		Temporomandibular Joint		
Forward Head Posture <input type="checkbox"/>	Narrow/Small Nares <input type="checkbox"/>		Range of Motion Normal Values: Lateral Excursion: 8-12 mm (each side), Vertical: 40-60mm, Protrusive: 8-12mm (total back + forward)		
Head Tilt <input type="checkbox"/>	Flat Upper Lip <input type="checkbox"/>		*Pain Score: 0 through 10, 0 = No Pain, 10 = Worst Imaginable Pain		
Retrognathic Maxilla <input type="checkbox"/>	Submandibular Pannus <input type="checkbox"/>		Assessment	Lateral (R)	Lateral (L)
Retrognathic Mandible <input type="checkbox"/>			Limited <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Function			ROM _____mm	_____mm	_____mm
Nasal Valve Collapse <input type="checkbox"/>	Cottle Maneuver		Pain Score* _____	_____	_____
Nasal Congestion (R) <input type="checkbox"/>	(+) Improved <input type="checkbox"/>		Joint Evaluation		
Nasal Congestion (L) <input type="checkbox"/>	(-) Not Improved <input type="checkbox"/>		(R) (L)		
Mouth Breathing <input type="checkbox"/>	Undetermined <input type="checkbox"/>		Early Click on Open <input type="checkbox"/> <input type="checkbox"/>		
Palpation			Late Click on Open <input type="checkbox"/> <input type="checkbox"/>		
*Palpation Tenderness Scale: 0 = No Tenderness, +1 = Tenderness without grimace or flinch, +2 = Tenderness with grimace or flinch, +3 = Tenderness with withdrawal, +4 = Withdrawal to non-noxious stimuli					
Temporalis:					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
Masseter:					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
Digastric:					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
SCM:					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
TMJ (capsulitis):					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
Medial Pterygoid					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
Lateral Pterygoid					
(R)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
(L)	0 <input type="checkbox"/>	+1 <input type="checkbox"/>	+2 <input type="checkbox"/>	+3 <input type="checkbox"/>	+4 <input type="checkbox"/>
<u>Additional head and Jaw Findings</u>					

Clinical Evaluation (Head and Neck Exam)

Intraoral Exam														
<p>Midlines</p> <table style="width: 100%;"> <tr> <td style="width: 50%;"> Skeletal Midline (Maxilla) Symmetrical <input type="checkbox"/> Asymm. To Right _____mm Asymm. To Left _____mm </td> <td style="width: 50%;"> Dental Midline (Mandible in occlusion) Symmetrical <input type="checkbox"/> Asymm. To Right _____mm Asymm. To Left _____mm </td> </tr> </table>	Skeletal Midline (Maxilla) Symmetrical <input type="checkbox"/> Asymm. To Right _____mm Asymm. To Left _____mm	Dental Midline (Mandible in occlusion) Symmetrical <input type="checkbox"/> Asymm. To Right _____mm Asymm. To Left _____mm	<p>Tongue</p> <p>Macroglossia <input type="checkbox"/></p> <p>Glossitis/Geographic <input type="checkbox"/></p> <p>Scalloped <input type="checkbox"/></p> <p>Fissured <input type="checkbox"/></p> <p>Swallow</p> <p>Anterior tongue thrust <input type="checkbox"/></p> <p>Lateral tongue thrust <input type="checkbox"/></p> <p>Other Dysphagia (Abnormal Swallow) <input type="checkbox"/></p> <p>Range of Motion</p> <p>TTS (Tongue Tip to the Spot) _____mm</p> <p>GPS (Glossal Palate Suction) _____mm</p> <p>Floor of mouth lifting <input type="checkbox"/></p> <p>Speech</p> <p>Speech Issue <input type="checkbox"/></p>											
Skeletal Midline (Maxilla) Symmetrical <input type="checkbox"/> Asymm. To Right _____mm Asymm. To Left _____mm	Dental Midline (Mandible in occlusion) Symmetrical <input type="checkbox"/> Asymm. To Right _____mm Asymm. To Left _____mm													
<p>Mallampati</p> <p>Class I: Soft palate, uvula, fauces and pillars visible. Class II: Soft palate, majority of uvula and fauces visible. Class III: Soft palate and base of uvula visible. Class IV: Only hard palate visible.</p>	<p>General Oral Health</p> <table style="width: 100%;"> <tr> <td>Erythroplakia <input type="checkbox"/></td> <td>Xerostomia <input type="checkbox"/></td> </tr> <tr> <td>Aphthous Ulcer <input type="checkbox"/></td> <td>Leukoplakia <input type="checkbox"/></td> </tr> <tr> <td>Lichen Planus <input type="checkbox"/></td> <td>Herpetic Lesion <input type="checkbox"/></td> </tr> <tr> <td>Sialolithiasis <input type="checkbox"/></td> <td>Mucocele <input type="checkbox"/></td> </tr> <tr> <td>Linea Alba (cheek) <input type="checkbox"/></td> <td>Hypersalivation <input type="checkbox"/></td> </tr> <tr> <td>Cleft Lip <input type="checkbox"/></td> <td>Angular Cheilitis <input type="checkbox"/></td> </tr> </table> <p>Periodontal Health</p> <p>Gingivitis <input type="checkbox"/></p>	Erythroplakia <input type="checkbox"/>	Xerostomia <input type="checkbox"/>	Aphthous Ulcer <input type="checkbox"/>	Leukoplakia <input type="checkbox"/>	Lichen Planus <input type="checkbox"/>	Herpetic Lesion <input type="checkbox"/>	Sialolithiasis <input type="checkbox"/>	Mucocele <input type="checkbox"/>	Linea Alba (cheek) <input type="checkbox"/>	Hypersalivation <input type="checkbox"/>	Cleft Lip <input type="checkbox"/>	Angular Cheilitis <input type="checkbox"/>	Maxillary Arch
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Cleft Lip <input type="checkbox"/>	Angular Cheilitis <input type="checkbox"/>													
Active Periodontitis <input type="checkbox"/>	Ovoid <input type="checkbox"/>													
Periodontitis (History) <input type="checkbox"/>	Tapered <input type="checkbox"/>													
Poor oral hygiene <input type="checkbox"/>	Square <input type="checkbox"/>													
	Hourglass <input type="checkbox"/>													
	Narrow <input type="checkbox"/>													

Tonsils *Grade 0: Removed (no tonsils seen), Grade 1: In tonsillar fossa Grade 2: Visible beyond anterior pillars, Grade 3: extended ¾ of way to midline, Grade 4: Completely obstructing airway "kissing tonsils"*	**Tori/Exostoses**						--	--------------------------	--------------------------	--------------------------			Mild	Moderate	Severe		Palatal Torus <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Lingual Tori <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Buccal Exostoses (Maxilla) <input type="checkbox"/>					Buccal Exostoses (Mandible) <input type="checkbox"/>												
Oropharynx				---	---		Ulceration <input type="checkbox"/>	Petechiae <input type="checkbox"/>		Enlarged Uvula <input type="checkbox"/>	Sensitive Gag Reflex <input type="checkbox"/>		Inflammation <input type="checkbox"/>			**Hard Palate** Vaulted Ulcerated Cleft																												
Frenum Ankyloglossia (Tongue Tie) Excessive Midline Labial Tie (upper) Excessive Midline Labial Tie (Lower) Excessive Buccal Tie Lingual Frenulum Assessment Score (0-10): _____								---	---	---	---	---	---		No Tie 0	Mild 1-2	Mild-Mod 3-4	Moderate 5-6	Mod-Severe 7-8	Severe 9-10									**Radiograph Order(s)**				---	--		70140 AP Skull <input type="checkbox"/>	70355 Orthopantogram <input type="checkbox"/>		70220 Paranasal Sinuses <input type="checkbox"/>	76100 TMJ Tomography <input type="checkbox"/>		70350 Lateral Skull (Ceph) <input type="checkbox"/>	70250 Submentoverteax <input type="checkbox"/>	**Clinical Notes** _____ _____ **Doctor Signature:** _____ **Date:** _____

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Intraoral Dental Exam																																																																																																																																																																																																																																													
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<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Tooth #</th> <th>Missing</th> <th>Implants</th> <th>Bridges</th> <th>Impacted</th> <th>Caries</th> <th>Perio</th> </tr> </thead> <tbody> <tr><td>1</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>2</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>3</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>4</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input 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type="checkbox"/>	31	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(R) (L) Class I Normal <input type="checkbox"/> <input type="checkbox"/> Class I Malocclusion <input type="checkbox"/> <input type="checkbox"/> Class II Malocclusion (Div I) <input type="checkbox"/> <input type="checkbox"/> Class II Malocclusion (Div II) <input type="checkbox"/> <input type="checkbox"/> Class III Malocclusion <input type="checkbox"/> <input type="checkbox"/>		
Tooth #	Missing	Implants	Bridges	Impacted	Caries	Perio																																																																																																																																																																																																																																							
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Clinical Evaluation (Head and Neck Exam)

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