MOUNTAINS
TMJ & DENTAL
SLEEP MEDICINE

Phone - 0447 436 853
Email - trevor.baret@mdsm.com.au
Web - www.mdsm.com.au

# Adult Orthodontic Screening

Patient Name (Print) _____ **Date:** ____/____/_____

## Section 1: First Impressions

Please tick one yes or no response for each question.

| | No | Yes |
|---|---|---|
| Does the patient regularly mouth breathe? | ❑ | ❑ |
| Are the front teeth crooked? | ❑ | ❑ |
| Do the upper front teeth appear to protrude? | ❑ | ❑ |

## Section 2: Subjective TMJ & Muscle Evaluation

Please tick one yes or no response for each question.

| | No | Yes |
|---|---|---|
| Does the patient grind their teeth in their sleep? | ❑ | ❑ |
| Does the patient wake up at night or in the mornings with headaches? | ❑ | ❑ |
| Does the patient snore? | ❑ | ❑ |
| Does the patient have enlarged tonsils? | ❑ | ❑ |
| Does the patient such their thumb or fingers? | ❑ | ❑ |
| Does the patient use a dummy or pacifier? | ❑ | ❑ |
| Are there cross-bites in anterior or posterior teeth? | ❑ | ❑ |
| Anterior ❑ Posterior ❑ | | |
| Does the upper dental arch look narrow? | ❑ | ❑ |
| Does the patient have nasal airway problems? | ❑ | ❑ |
| Does the patient have allergies? | ❑ | ❑ |
| Does the patient have difficulty closing their lips together normally and relaxed? | ❑ | ❑ |
| Is there a tongue-tie? | ❑ | ❑ |
| Does the patient have any speech impediment? | ❑ | ❑ |
| Does the patient have a TMJ-related Disorder? | ❑ | ❑ |
| Check TMD Patient Screening | | |
| Does the patient have SRBD? | ❑ | ❑ |
| Check Sleep Patient Screening | | |

## Section 3: Prior Orthodontic Diagnosis

Please fill in the blanks, and tick one yes or no response for each question

| | No | Yes |
|---|---|---|
| Has orthodontic treatment previously been recommended? | ❑ | ❑ |
| *If Yes:* When was it recommended? (Approx mo/yr) _____ | | |
| Did the patient see an Orthodontist for a consultation? | ❑ | ❑ |
| Is the patient seeking a second opinion? | ❑ | ❑ |