Extraoral Examination

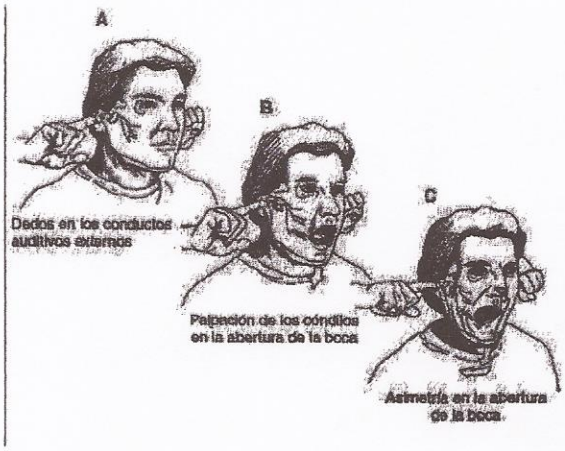
Patient Name:_____ Date: ___/___/___

Atm Exploration

Pain on palpation: Yes__ No__
Joint noise: Snap___ Crackling___

Oral Opening (Incapacity or Limitation): ___

Edema:___



Other:_____
_____

Intraoral Examination

Lips :_____
_____

Cheeks :_____
_____

Tongue :_____
_____

Mouth Floor :_____
_____

Retromolar Region :_____
_____

Pharynx :_____

Hard & Soft Palate :_____

Gums:_____

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