Oral Health Assessment and Review Checklist

Patient Name

For office use

CHI Number D D M M Y Y

Date of Assessment

Assessment Type FOHR / OHA

Day Month Year

Patient Histories Completed/Updated*	**Yes**	**No**	**Comment**
• Personal details	☐	☐	
• Social history	☐	☐	
• Dental history	☐	☐	
• Medical history	☐	☐	
• Dental anxiety level	☐	☐	
• Dentist reviewed histories	☐	☐	

**If new patient, complete new forms; if returning patient, ask patient if anything has changed and review forms completed previously*

Clinical Assessment Completed/Updated*	**Yes**	**No**	**Comment**
• Head and neck	☐	☐	
• Oral mucosal tissue	☐	☐	
• Periodontal tissue (BPE/plaque scores)	☐	☐	
• Teeth - Caries and restorations	☐	☐	
- Tooth surface loss	☐	☐	
- Tooth abnormalities	☐	☐	
- Fluorosis	☐	☐	
- Dental trauma	☐	☐	
• Occlusion	☐	☐	
• Orthodontic needs	☐	☐	

	Yes	**No**	**N/A**	
Dentures	☐	☐	☐	

**Record full details of any significant findings separately.*

	Good	**Poor**	**N/A**	**Comment**
Effectiveness of treatment	☐	☐	☐	

	Yes	**No**	
Patient compliance with advice	☐	☐	

Risk Assessment	**High**	**Medium**	**Low**	**Comment**
• Oral mucosal disease	☐	☐	☐	
• Periodontal disease	☐	☐	☐	
• Caries	☐	☐	☐	
• Other (please note)	☐	☐	☐	
OVERALL RISK	☐	☐	☐	

	Yes	**No**	**Comment**
Prevention advice given	☐	☐	
Preventive treatment required	☐	☐	
Operative treatment required	☐	☐	

Review Interval (months) (following completion of any treatment):

3 6 9 12 15 18 21 24

Proposed date for next OHA (following completion of any treatment):

	No Change	**Change**	**Comment**
Personal Care Plan Review	☐	☐	