Patient's Personal Details — Form 1

Please write clearly

For office use
CHI Number D D M M Y Y

Title (Please tick appropriate box)

☐ Mr ☐ Mrs ☐ Ms ☐ Miss

☐ Other (Please state below)

_____

Surname

Forename

Sex ☐ Male ☐ Female

Date of Birth

Day ☐☐ Month ☐☐ Year ☐☐☐☐

Family Name at Birth

Occupation

If retired, previous occupation

Permanent Address

Postcode

Email Address

Contact Phone No.

Doctor's Name

Doctor's Address

Postcode

Doctor's Phone No.

Ethnicity (Please tick appropriate box)

White ☐

Black, Black British, Black Scottish ☐

Asian, Asian British, Asian Scottish ☐

Mixed (Please state) ☐ _____

Other ethnic background (Please state) ☐ _____

PTO

Patient's Personal Details — Form 1 (cont.)

If you are filling in this form on behalf of the patient, please also enter **YOUR OWN** details below.

Surname

Forename

Relationship to Patient

- ☐ Parent/Guardian
- ☐ Carer
- ☐ Other family member
- ☐ Other (Please state)

_____

If you are a carer, please state how long you have attended the patient.

Months ☐☐ Years ☐☐

Address

(If different from patient's permanent address)

Postcode

Phone No.

Additional Information

After you have completed this form please return it to a member of the Dental Team.

Signature of Patient, Parent or Carer

_____

Date

_____

Social and Dental History — Form 2

Please write clearly

For office use
CHI Number D D M M Y Y

Surname _____

Forename _____

When did you last see a dentist? (If you cannot remember please tick the option most likely)

- ☐ Within the past 6 months
- ☐ 6 months to 1 year ago
- ☐ 1 - 2 years ago
- ☐ More than 2 years ago
- ☐ Never been to the dentist

Please tick appropriate box	Yes	No	Unsure	Further details
Have you received any dental treatment under local anaesthetic (injection in the gum)? If yes, please note whether it caused you any problems	☐	☐	☐	_____
Do you currently have any problems or concerns with your teeth, gums or mouth?	☐	☐	☐	_____
Do you play a sport where you have the potential to damage your teeth?	☐	☐	☐	_____
Do you wear a denture, brace or retainer?	☐	☐	☐	_____
As far as you are aware do you grind or clench your teeth?	☐	☐	☐	_____
Do you have a family history of gum disease (periodontitis)?	☐	☐	☐	_____
Are you anxious or nervous about attending the dentist?	☐	☐	☐	_____

Which of the following do you use each day? (Please tick appropriate boxes)

- ☐ Fluoride toothpaste
- ☐ Sugar-free chewing gum
- ☐ Mouthwash
- ☐ Fluoride tablets or drops
- ☐ Dental floss or any other oral health
- ☐ Not applicable

Which of the following do you have each day? (Please tick appropriate boxes)

- ☐ Sugary carbonated (fizzy) drinks
- ☐ Around 5 portions of fruit and vegetables
- ☐ Diet carbonated (fizzy) drinks
- ☐ Sugary treats (sweets and biscuits) between meals
- ☐ Sugar in hot drinks

PTO

Social and Dental History — Form 2 (cont.)

Have you ever used chewing tobacco, paan, gutkha supari or beetle quid?
(Please tick appropriate box)

Yes	No	Unsure	Please specify
☐	☐	☐	_____

Smoking Status (Please tick appropriate box)

☐ I have never smoked

☐ I am an ex-smoker — Number of years an ex-smoker _____

☐ I am a smoker — Number of cigarettes etc smoked per day _____

Alcohol Consumption

1 unit of alcohol = half a standard 175ml glass of wine (12.5% abv)
half a pint of normal strength beer, lager or cider (4% abv)
one 25 ml measure of spirits (40% abv)

On average how many units do you drink in a week? _____ units

What is the largest number of units you drank in a single day in the last week? _____ units

All Patients

In your view, how likely is it that the health of your teeth will affect your overall wellbeing?
(Please tick appropriate box)

☐	☐	☐	☐	☐
1	2	3	4	5
Not likely at all				Very likely

Additional Information

After you have completed this form please return it to a member of the Dental Team.

Signature of Patient, Parent or Carer _____ **Date** _____

Medical History

Form 3

Please write clearly

For office use

CHI Number D D M M Y Y

Surname

Forename

Please tick appropriate box. If you have further details, including any allergies or pills, tablets or other medication that you take, **please enter them in the 'Further Details' box.**

	Yes	No	Unsure
Are you aware of anything that you are allergic to? (penicillin or another antibiotic, pollen, latex, food, jewellery or any other substance)	☐	☐	☐
Have you ever had any heart problems/conditions? (blood pressure problems, angina or chest pains, pacemaker or any other heart or blood vessel condition)	☐	☐	☐
Have you ever had any chest or breathing problems/conditions? (asthma, bronchitis or any other breathing problems)	☐	☐	☐
Have you ever had any stomach, gut, liver or kidney problems/conditions?	☐	☐	☐
Do you have any blood or bleeding problems/conditions?	☐	☐	☐
Are you prone to fits/faints or do you have epilepsy?	☐	☐	☐
Do you have any problems or conditions relating to your bones, joints or muscles? (arthritis, muscle weakness or any other condition)	☐	☐	☐
Do you have hepatitis, HIV, AIDS or tuberculosis (TB)?	☐	☐	☐
Are you pregnant or is there a possibility you could be pregnant?	☐	☐	☐
Do you have diabetes?	☐	☐	☐
Do you have a medical condition or problem not specified above?	☐	☐	☐
Are you currently under treatment from a doctor, consultant or clinic?	☐	☐	☐
Do you carry a medical warning card?	☐	☐	☐
Are you taking or meant to take medicine prescribed by your doctor or otherwise? (tablets, pills, patches, medicines, inhalers, ointments, injections, oral contraceptives, herbal remedies, recreational drugs, recent vaccinations). If yes, please enter them in the 'Further Details' box overleaf.	☐	☐	☐
Are there any conditions that run in your family? (diabetes, sickle cell disease or any other conditions). If yes, please enter them in the 'Further Details' box overleaf.	☐	☐	☐
Have you ever had an illness or operation that required hospital treatment? If yes, please enter them in the 'Further Details' box overleaf.	☐	☐	☐

PTO

Medical History — Form 3 (cont.)

Additional Requirements or Special Needs (Please tick appropriate box or boxes)

- ☐ Visual impairment
- ☐ Hearing difficulties
- ☐ Learning difficulties
- ☐ Communication difficulties
- ☐ Mental health difficulties
- ☐ Physical disability
- ☐ Wheelchair user
- ☐ Hoist transfer required
- ☐ None
- ☐ Other (Please give details if appropriate)

If you are an armed forces veteran, please tick here ☐

Further Details including any allergies or pills, tablets or other medication that you take

After you have completed this form please return it to a member of the Dental Team.

Signature of Patient, Parent or Carer _____

Date _____

Patient History Update

Patient Name

_____

For office use

CHI Number D D M M Y Y

For returning patients, review the patient history forms completed previously and ensure that the information provided is up to date and accurate. Changes can be recorded below.

Date	Changes	Signature of Patient, Parent or Carer

Dental Anxiety Questionnaire — Form 4

Please write clearly

For office use

CHI Number D D M M Y Y

Surname

Forename

Please fill in part A (below) or part B (overleaf). Choose the side that suits you best.

A Please tell us how anxious you get about your dental visit? (Please tick appropriate box)

If you went to your dentist for **treatment tomorrow**, how would you feel?

☐ Not Anxious ☐ Slightly Anxious ☐ Fairly Anxious

☐ Very Anxious ☐ Extremely Anxious

If you were sitting in the **waiting room** (waiting for treatment), how would you feel?

☐ Not Anxious ☐ Slightly Anxious ☐ Fairly Anxious

☐ Very Anxious ☐ Extremely Anxious

If you were about to have a **tooth drilled**, how would you feel?

☐ Not Anxious ☐ Slightly Anxious ☐ Fairly Anxious

☐ Very Anxious ☐ Extremely Anxious

If you were about to have your **teeth scaled and polished**, how would you feel?

☐ Not Anxious ☐ Slightly Anxious ☐ Fairly Anxious

☐ Very Anxious ☐ Extremely Anxious

If you were about to have a **local anaesthetic injection** in your gum, above an upper back tooth, how would you feel?

☐ Not Anxious ☐ Slightly Anxious ☐ Fairly Anxious

☐ Very Anxious ☐ Extremely Anxious

PTO

Dental Anxiety Questionnaire — Form 4 (cont.)

B For the next 6 questions I would like you to show me how relaxed or worried you get about the dentist and what happens at the dentist. To show me how relaxed or worried you feel, please use the simple scale below. The scale is just like a ruler going from 1, which would show that you are relaxed, to 5, which would show that you are very worried. (Please circle the appropriate number on the scale).

 **1** would mean: relaxed/not worried

 **2** would mean: very slightly worried

 **3** would mean: fairly worried

 **4** would mean: worried a lot

 **5** would mean: very worried

How do you feel about...					
...going to visit the dentist?	1	2	3	4	5
...having your teeth looked at?	1	2	3	4	5
...having your teeth cleaned and polished?	1	2	3	4	5
...having an injection in the gum?	1	2	3	4	5
...having a filling?	1	2	3	4	5
...having a tooth taken out?	1	2	3	4	5

Additional Information

After you have completed this form please return it to a member of the Dental Team.

Signature of Patient, Parent or Carer **Date**

Assessment of Head and Neck — Form 5

Surname _____

Forename _____

Age ☐☐ Sex ☐

For office use

CHI Number D D M M Y Y ☐☐☐☐☐☐☐☐☐☐

Examination Date

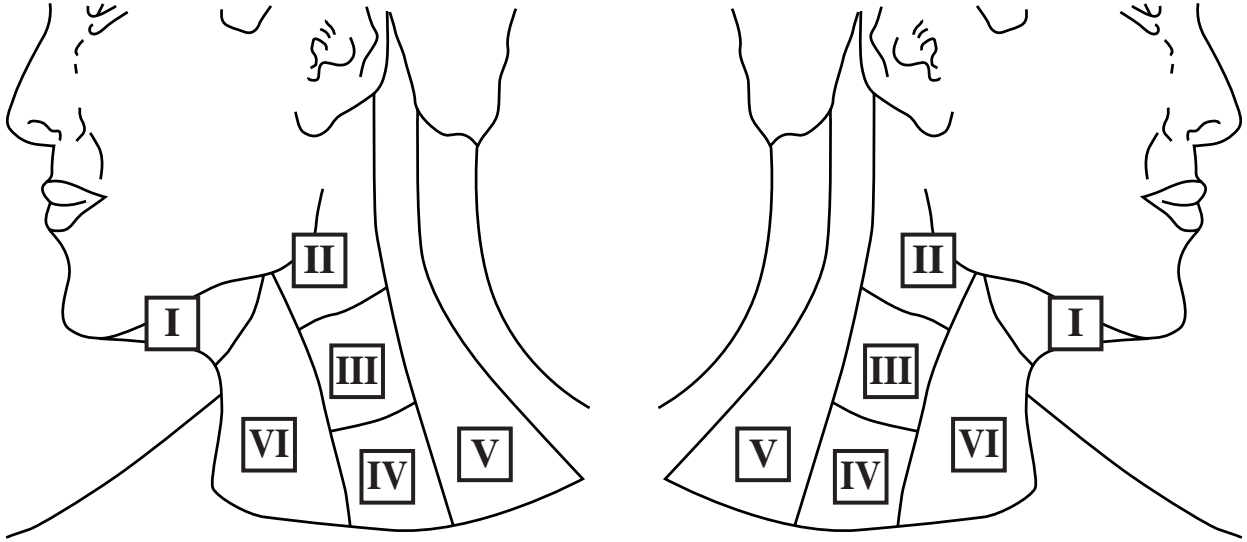
Day ☐☐ Month ☐☐ Year ☐☐☐☐

Assessment of: Please tick boxes when examination is completed

Skin (including swellings) ☐ Facial bones ☐

TMJ ☐ Lymph nodes ☐

Please circle as appropriate, if an abnormality is found in the following groups of lymph nodes.



Note of abnormalities found

Referral (Please tick)

No referral required ☐

Non-urgent referral ☐ Urgent referral ☐

Signature of Practitioner _____ **Date** _____

Assessment of Oral Mucosal Tissue

Form 6

For office use

CHI Number D D M M Y Y

Surname _____

Forename _____

Age ☐☐ Sex ☐

Examination Date

Day ☐☐ Month ☐☐ Year ☐☐☐☐

	Ulcer	White	Red	Swelling	Pigmented	Other
a. Upper lip	☐	☐	☐	☐	☐	☐
b. Lower lip	☐	☐	☐	☐	☐	☐
c. R commissure	☐	☐	☐	☐	☐	☐
d. L commissure	☐	☐	☐	☐	☐	☐
e. Upper labial mucosa	☐	☐	☐	☐	☐	☐
f. Upper sulci	☐	☐	☐	☐	☐	☐
g. Upper gingivae	☐	☐	☐	☐	☐	☐
h. Hard palate	☐	☐	☐	☐	☐	☐
i. Soft palate	☐	☐	☐	☐	☐	☐
j. Pharynx and tonsillar area	☐	☐	☐	☐	☐	☐
k. Tongue - dorsum	☐	☐	☐	☐	☐	☐
l. Tongue - R lateral border	☐	☐	☐	☐	☐	☐
m. Tongue - L lateral border	☐	☐	☐	☐	☐	☐
n. Tongue - ventral	☐	☐	☐	☐	☐	☐
o. Floor of mouth	☐	☐	☐	☐	☐	☐
p. R buccal mucosa	☐	☐	☐	☐	☐	☐
q. L buccal mucosa	☐	☐	☐	☐	☐	☐
r. Lower gingivae	☐	☐	☐	☐	☐	☐
s. Lower sulci	☐	☐	☐	☐	☐	☐
t. Lower labial mucosa	☐	☐	☐	☐	☐	☐

Abnormal findings Yes ☐ No ☐

If yes, use the list on the left and / or the diagram overleaf to note details of any abnormal finding.

Referral (Please tick)

No referral required ☐

Non-urgent referral ☐ Urgent referral ☐

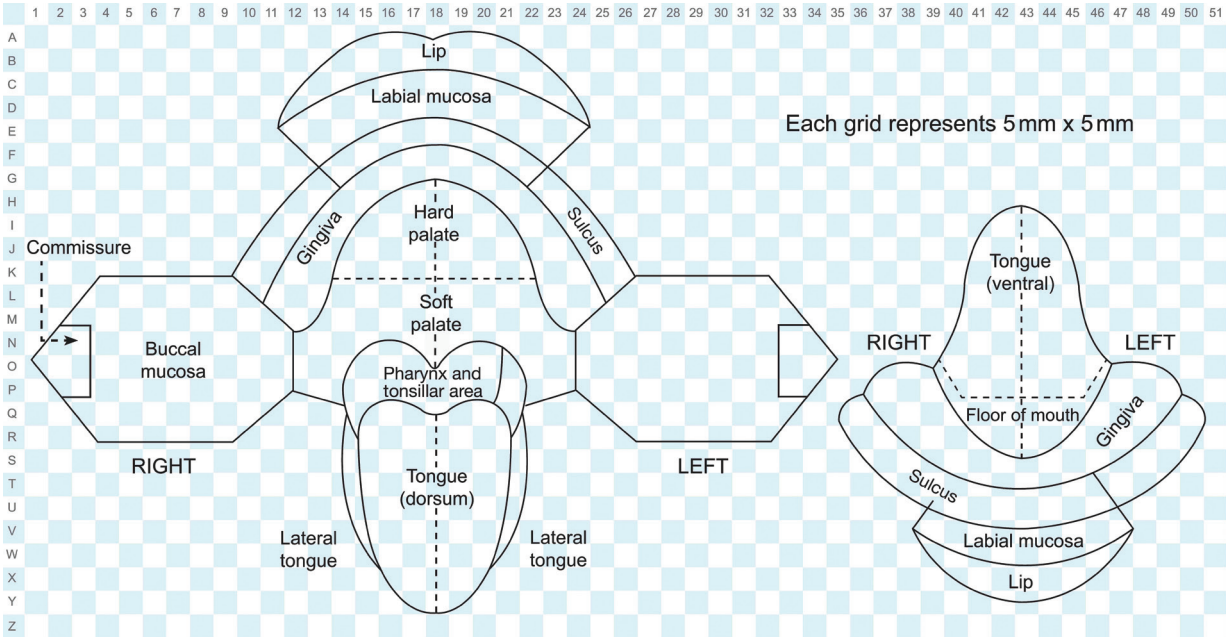
Notes

Signature of Practitioner _____ **Date** _____

PTO

Assessment of Oral Mucosal Tissue — Form 6 (cont.)

Record the extent of any pathology on the mouth map and describe it below:



Description and notes:

Monitoring 1

Date	Signature of Practitioner

Has lesion changed since previous examination? Yes ☐ No ☐

Lesion description / Notes

Monitoring 2

Date	Signature of Practitioner

Has lesion changed since previous examination? Yes ☐ No ☐

Lesion description / Notes

Monitoring 3

Date	Signature of Practitioner

Has lesion changed since previous examination? Yes ☐ No ☐

Lesion description / Notes

Signature of Practitioner _____ **Date** _____

Assessment of Teeth

Form 7

For office use

D D M M Y Y

CHI Number | | | | | | | | | | |

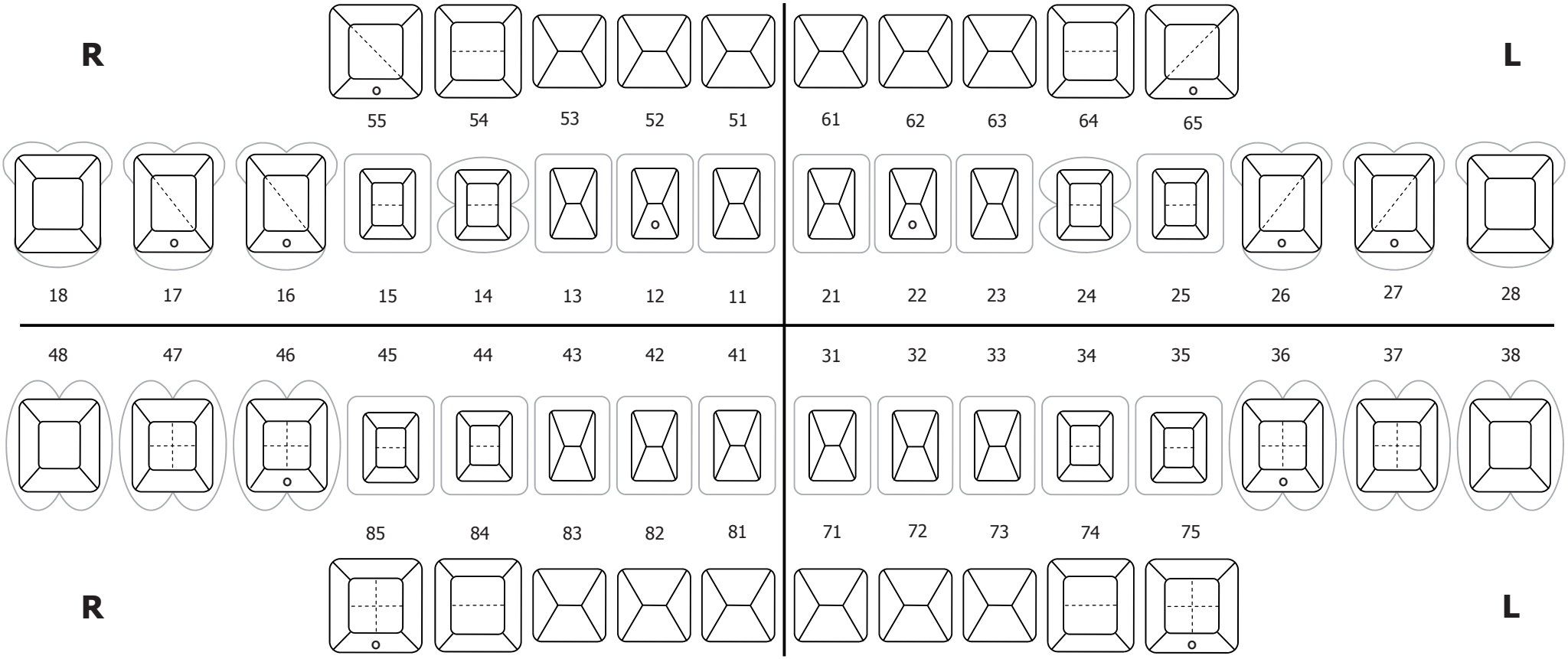
Surname _____

Forename _____

Age | | Sex | |

Examination Date

Day | | Month | | Year | | | |



Type of examination completed: Basic | | Full | |

Signature of Practitioner _____ **Date** _____

Basic Periodontal Examination and Dentition Care Requirements — Form 8

For office use

D D M M Y Y

CHI Number | | | | | | | | | | |

Surname _____

Forename _____

Age | | Sex |

Examination Date

Day | | Month | | Year | | | |

Basic Periodontal Examination

Code	Visible Signs
0	No bleeding or pocketing detected
1	Bleeding on probing; no pocketing
2	Plaque-retentive factors present; no pocketing >3.5 mm

Code	Visible Signs
3	Pockets >3.5 mm but <5.5 mm in depth
4	Pockets >5.5 mm in depth
*****	Loss of attachment of 7 mm or presence of furcation involvement

Dentition Care Requirements

Prevention		
New Restoration		
Re-restoration		
Extraction		
Other		

Notes

Signature of Practitioner _____ **Date** _____

Radiographic Assessment

Form 9

For office use

D D M M Y Y

CHI Number | | | | | | | | | | |

Surname _____

Forename _____

Age | | Sex | |

Examination Date

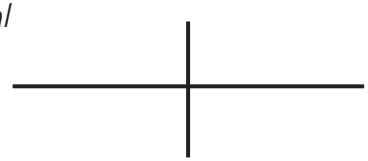
Day | | Month | | Year | | | |

Type of film(s)

Bitewings Horizontal R L *Periapical*
Vertical R L

Occlusal Upper Lower

Extra-oral OPG Lateral Ceph *Other*



Quality of films taken

Radiation Dose / Setting

Clinical indication for taking film(s), and suspected diagnosis

Radiographic Report

Clinical examination undertaken by:

Date

Films authorised by:

Date

Films taken by:

Date

Signature of Practitioner _____ **Date** _____

Assessment of Dentures *(if required)* — Form 10

For office use

CHI Number D D M M Y Y

Surname _____

Forename _____

Age ☐☐ Sex ☐

Examination Date

Day ☐☐ Month ☐☐ Year ☐☐☐☐

Patient's Assessment of Dentures

	Yes	No	Unsure
Are you happy with the appearance of your dentures?	☐	☐	☐
Do your dentures move?	☐	☐	☐
Are your dentures comfortable?	☐	☐	☐
Do your dentures affect your speech?	☐	☐	☐
Are you able to chew adequately?	☐	☐	☐
Are you able to bite adequately?	☐	☐	☐

Clinician's Assessment of Dentures

Denture Base Material

Acrylic ☐ Cobalt Chrome ☐

Denture Hygiene

Good ☐

Fair ☐

Poor ☐

Type of Denture

F/F ☐ P/P ☐ F/P ☐

P/F ☐ F/– ☐ –/F ☐

P/– ☐ –/P ☐

Upper Denture	Good	Poor	N/A
Tissue adaption	☐	☐	☐
Base extension	☐	☐	☐
Labial	☐	☐	☐
Buccal	☐	☐	☐
Posterior border	☐	☐	☐
Tuberosity	☐	☐	☐
Labial fullness	☐	☐	☐

	Good	Poor	N/A
Incisal level	☐	☐	☐
Incisal plane	☐	☐	☐
Position of posterior teeth	☐	☐	☐
Occlusal plane level	☐	☐	☐
Occlusal plane orientation	☐	☐	☐
Arch width	☐	☐	☐
Buccal–lingual width	☐	☐	☐

Alteration proposed / Notes

PTO

Assessment of Dentures *(if required)* — Form 10 (cont.)

Lower Denture	Good	Poor	N/A		Good	Poor	N/A	Alteration proposed / Notes
Tissue adaption	☐	☐	☐	Labial fullness	☐	☐	☐	
Base extension	☐	☐	☐	Position of posterior teeth	☐	☐	☐	
Labial	☐	☐	☐	Occlusal plane level	☐	☐	☐	
Buccal	☐	☐	☐	Arch width	☐	☐	☐	
Posterior border	☐	☐	☐	Buccal–lingual width	☐	☐	☐	
Lingual	☐	☐	☐	Cusp form	☐	☐	☐	
Distolingual	☐	☐	☐					

Relationship of Dentures

Occlusal Position *(Select one)*

- Retruded ☐
- Protruded ☐
- Intercuspal / Muscular ☐

Occlusal Contacts	Good	Poor	N/A	Alteration proposed / Notes
Articulation	☐	☐	☐	
Occlusal vertical dimension	☐	☐	☐	
Incisal overjet	☐	☐	☐	
Incisal overbite	☐	☐	☐	

Aesthetics

	Good	Poor	Alteration proposed / Notes
Mould / Arrangement	☐	☐	
Shade	☐	☐	

Signature of Practitioner _____ **Date** _____

Patient Review and Personal Care Plan

A summary of the status of your oral health is summarised below with details of when your next review or assessment will be.

Surname

Forename

Examination Date

Day ☐☐ Month ☐☐ Year ☐☐☐☐

Dentist's Details

Phone No.

Assessment of Oral Health Status

	High Risk	Medium Risk	Low Risk
Soft tissue disease assessment	☐	☐	☐
Gum disease assessment	☐	☐	☐
Tooth decay assessment	☐	☐	☐
Other assessment (details below)	☐	☐	☐

Overall risk of future dental problems ☐ ☐ ☐

Your next review or assessment

After your treatment is complete, your next check-up with your dentist / hygienist / nurse will be in:

patient under 18 years

3 months ☐ 6 months ☐

9 months ☐ 12 months ☐

patient 18 years and over

3 months ☐ 6 months ☐ 9 months ☐

12 months ☐ 15 months ☐ 18 months ☐

21 months ☐ 24 months ☐

Type of assessment ☐ Focussed review ☐ Full assessment

If you have problems or concerns about your oral health before your next scheduled visit, contact your dental practice.

PTO

Patient Review and Personal Care Plan (cont.)

Things you can do to maintain or improve your oral health are shown below followed by what the dental team plans to do.

Actions for the Patient

Actions for the Dental Team

Prevention

Treatment

Maintenance

Referral

Signature of Patient, Parent or Carer **Date**

Signature of Practitioner **Date**

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	☐	☐	