

Patient's Personal Details

Form 1

For office use

D D M M Y Y

Please write clearly

CHI Number

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Title (Please tick appropriate box)

Mr Mrs Ms Miss

Other (Please state below)

Surname

Permanent Address

Postcode

Forename

Email Address

Sex

Male

Female

Contact Phone No.

Date of Birth

Day Month Year

Doctor's Name

Family Name at Birth

Doctor's Address

Occupation

Postcode

If retired, previous occupation

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) _____

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)
- _____

Address

(If different from patient's permanent address)

Postcode

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

Months Years

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

Please write clearly

For office use

D D M M Y Y

CHI Number

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Surname

Forename

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Within the past 6 months | <input type="checkbox"/> 6 months to 1 year ago | <input type="checkbox"/> 1 - 2 years ago |
| <input type="checkbox"/> More than 2 years ago | <input type="checkbox"/> 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

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Do you currently have any problems or concerns with your teeth, gums or mouth?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Do you play a sport where you have the potential to damage your teeth?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Do you wear a denture, brace or retainer?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

As far as you are aware do you grind or clench your teeth?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Do you have a family history of gum disease (periodontitis)?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

Are you anxious or nervous about attending the dentist?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Fluoride toothpaste | <input type="checkbox"/> Sugar-free chewing gum | <input type="checkbox"/> Mouthwash |
| <input type="checkbox"/> Fluoride tablets or drops | <input type="checkbox"/> Dental floss or any other oral health | <input type="checkbox"/> Not applicable |

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

- | | |
|---|--|
| <input type="checkbox"/> Sugary carbonated (fizzy) drinks | <input type="checkbox"/> Around 5 portions of fruit and vegetables |
| <input type="checkbox"/> Diet carbonated (fizzy) drinks | <input type="checkbox"/> Sugary treats (sweets and biscuits) between meals |
| <input type="checkbox"/> Sugar in hot drinks | |

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

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Signature of Patient, Parent or Carer

Date

Please write clearly

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CHI Number

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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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any heart problems/conditions? (blood pressure problems, angina or chest pains, pacemaker or any other heart or blood vessel condition)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any chest or breathing problems/conditions? (asthma, bronchitis or any other breathing problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any stomach, gut, liver or kidney problems/conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any blood or bleeding problems/conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you prone to fits/faints or do you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any problems or conditions relating to your bones, joints or muscles? (arthritis, muscle weakness or any other condition)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hepatitis, HIV, AIDS or tuberculosis (TB)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or is there a possibility you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a medical condition or problem not specified above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently under treatment from a doctor, consultant or clinic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you carry a medical warning card?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an illness or operation that required hospital treatment? If yes, please enter them in the 'Further Details' box overleaf.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Visual impairment | <input type="checkbox"/> Hearing difficulties | <input type="checkbox"/> Learning difficulties |
| <input type="checkbox"/> Communication difficulties | <input type="checkbox"/> Mental health difficulties | <input type="checkbox"/> Physical disability |
| <input type="checkbox"/> Wheelchair user | <input type="checkbox"/> Hoist transfer required | <input type="checkbox"/> None |
| <input type="checkbox"/> 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

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CHI Number

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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?

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Not Anxious | <input type="checkbox"/> Slightly Anxious | <input type="checkbox"/> Fairly Anxious |
| <input type="checkbox"/> Very Anxious | <input type="checkbox"/> Extremely Anxious | |

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

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Not Anxious | <input type="checkbox"/> Slightly Anxious | <input type="checkbox"/> Fairly Anxious |
| <input type="checkbox"/> Very Anxious | <input type="checkbox"/> Extremely Anxious | |

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

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Not Anxious | <input type="checkbox"/> Slightly Anxious | <input type="checkbox"/> Fairly Anxious |
| <input type="checkbox"/> Very Anxious | <input type="checkbox"/> Extremely Anxious | |


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

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Not Anxious | <input type="checkbox"/> Slightly Anxious | <input type="checkbox"/> Fairly Anxious |
| <input type="checkbox"/> Very Anxious | <input type="checkbox"/> Extremely Anxious | |


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

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Not Anxious | <input type="checkbox"/> Slightly Anxious | <input type="checkbox"/> Fairly Anxious |
| <input type="checkbox"/> Very Anxious | <input type="checkbox"/> Extremely Anxious | |

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

 **4** would mean: worried a lot

 **2** would mean: very slightly worried

 **5** would mean: very worried

 **3** would mean: fairly 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

D D M M Y Y

CHI Number

Examination Date

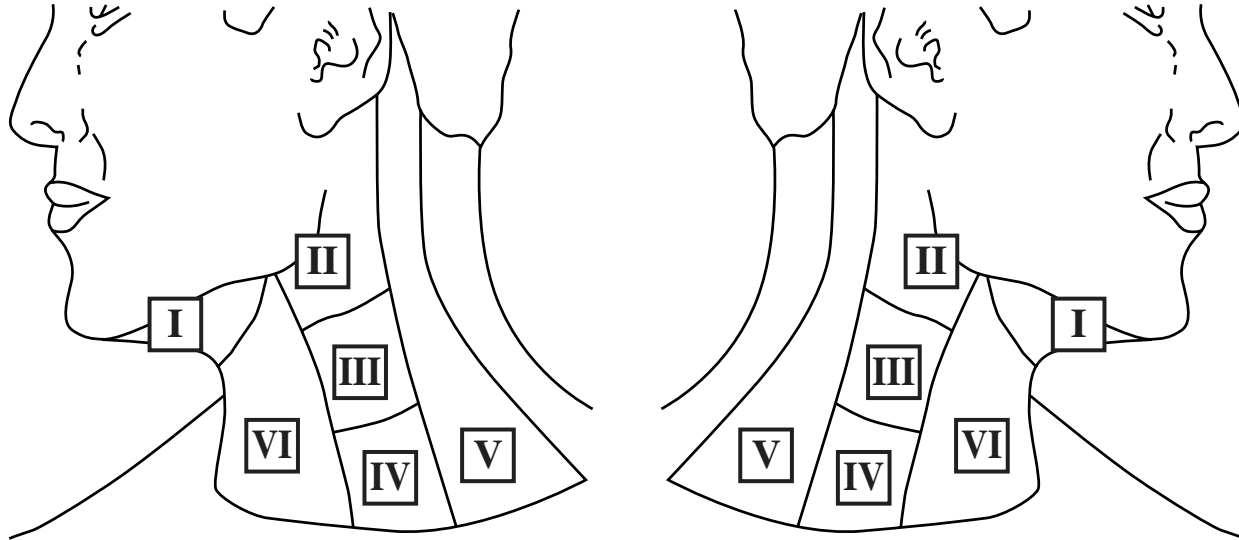
Day Month Year

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

Surname _____

Forename _____

Age

Sex

For office use

D D M M Y Y

CHI Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Examination Date

Day

Month

Year

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

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

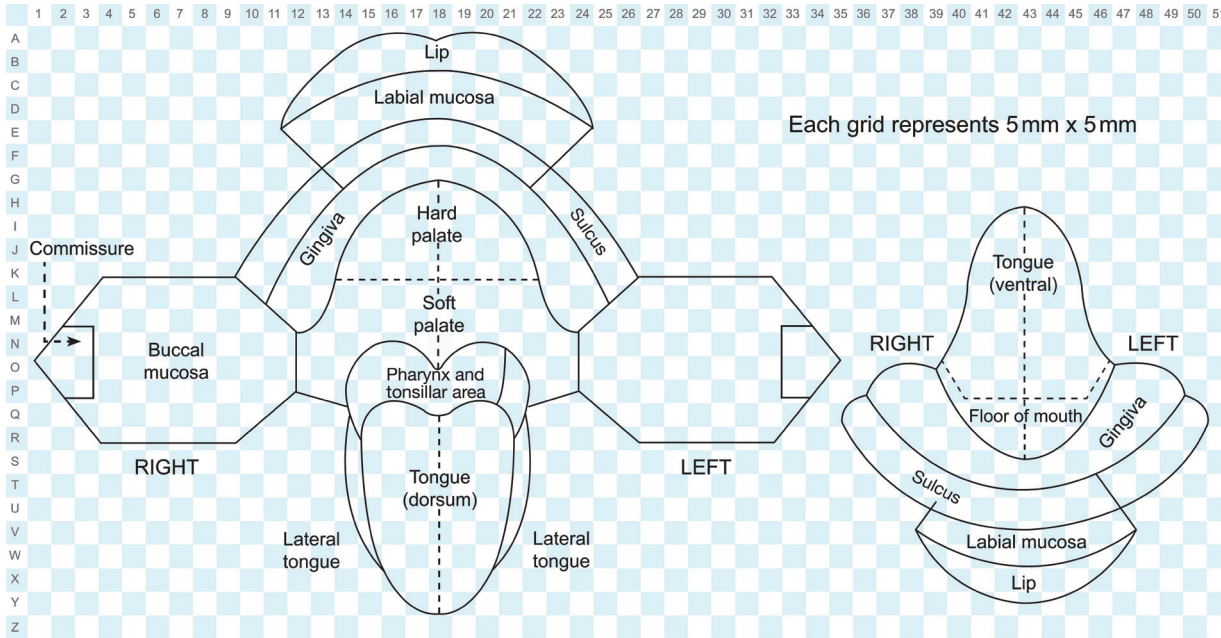
Signature of Practitioner _____

Date _____

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

Surname _____

Forename _____

Age

Sex

For office use

D D M M Y Y

CHI Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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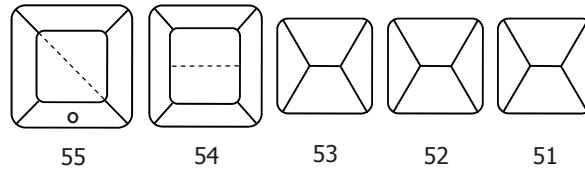
Examination Date

Day

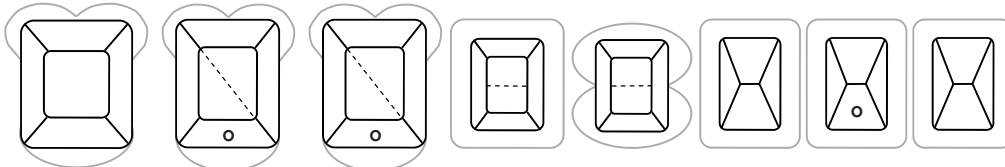
Month

Year

R

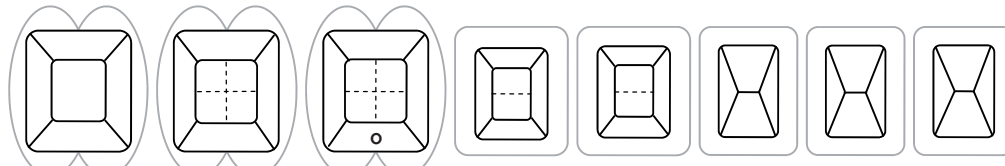


55 54 53 52 51

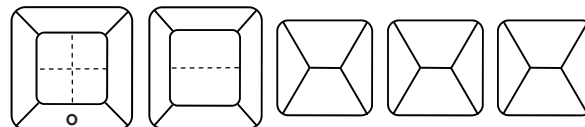


18 17 16 15 14 13 12 11

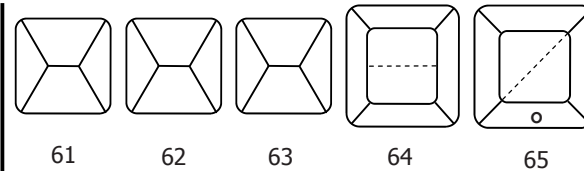
48 47 46 45 44 43 42 41



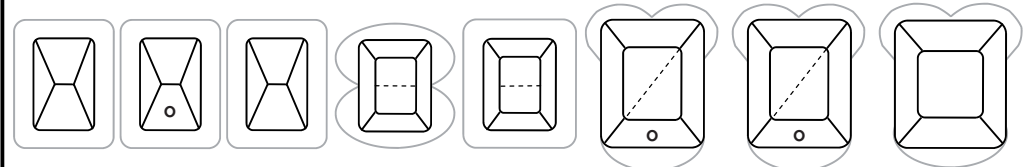
85 84 83 82 81



R

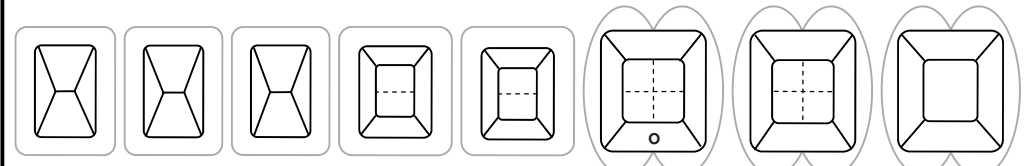


61 62 63 64 65

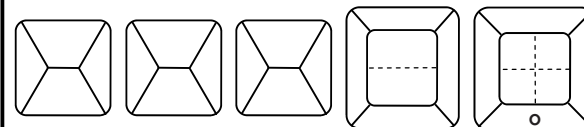


21 22 23 24 25 26 27 28

31 32 33 34 35 36 37 38



71 72 73 74 75



L

L

Type of examination completed: Basic Full

Signature of Practitioner _____

Date _____

Basic Periodontal Examination and Dentition Care Requirements

Form 8

Surname _____

Forename _____

Age

Sex

For office use

D D M M Y Y

CHI Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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

<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Dentition Care Requirements

Prevention	_____
New Restoration	_____
Re-restoration	_____
Extraction	_____
Other	_____

Notes

Signature of Practitioner _____

Date _____

Radiographic Assessment

Form 9

Surname _____

Forename _____

Age

Sex

For office use

D D M M Y Y

CHI Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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

Surname _____

Forename _____

Age

Sex

For office use

D D M M Y Y

CHI Number

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

Lower Denture	Good	Poor	N/A		Good	Poor	N/A	Alteration proposed / Notes
Tissue adaption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Labial fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Base extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Position of posterior teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Labial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occlusal plane level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Buccal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arch width	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Posterior border	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Buccal-lingual width	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lingual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cusp form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Distolingual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Relationship of Dentures		Occlusal Contacts			Alteration proposed / Notes
Occlusal Position	(Select one)	Good	Poor	N/A	
Retruded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Protruded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intercuspal / Muscular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Aesthetics		Alteration proposed / Notes	
	Good	Poor	
Mould / Arrangement	<input type="checkbox"/>	<input type="checkbox"/>	
Shade	<input type="checkbox"/>	<input type="checkbox"/>	

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

Dentist's Details

Forename

Examination Date

Day Month Year

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.

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

D D M M Y Y

CHI Number

--	--	--	--	--	--	--	--	--	--	--	--

Date of Assessment

Day Month Year

Assessment Type FOHR / OHA

Patient Histories Completed/Updated*

Yes No

Comment

- Personal details
- Social history
- Dental history
- Medical history
- Dental anxiety level
- Dentist reviewed histories

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**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

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Yes No N/A

Dentures

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Record full details of any significant findings separately.*

Effectiveness of treatment

Good Poor N/A

Comment

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Patient compliance with advice

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
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Risk Assessment

High Medium Low

Comment

- Oral mucosal disease
- Periodontal disease
- Caries
- Other (please note)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OVERALL RISK

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Prevention advice given

Yes No

Comment

<input type="checkbox"/>	<input type="checkbox"/>
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Preventive treatment required

<input type="checkbox"/>	<input type="checkbox"/>
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Operative treatment required

<input type="checkbox"/>	<input type="checkbox"/>
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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

<input type="checkbox"/>	<input type="checkbox"/>
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