**PATIENT:**

**AGE:**

CONSULTATION

Date of consultation:  Consultant: **A D POLONOWITA**

Referred by:

**Place of consultation:**

**MAIN COMPLAINT:**

**HISTORY**

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| **Date**  |  |
|  **Cardiovascular**  |  |
| **Respiratory**  |  |
| **GI Tract**  |  |
| **Smoking**  |  |
| **Alcohol**  |  |
| **Medications**  |  |
| **Allergies**  |  |
| **Other** |  |

**Pain History**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DESCRIPTION** | **HOT** | **COLD** | **SWEET** | **PRESSURE** | **SHARP** | **DULL** | **ACHING** | **SHOOTIN** | **ELECTRICAL** | **ANNOYING** | **BURNING** |
| **PAIN** | TOOTH      | MOUTH       | FACE      | L EAR      | R EAR      | L HEADACHE      | R HEADACHE      | L TMJ      | R TMJ      |  |  |
| **OTHER** | RECENT TRAUMA      | RECENT DENTAL TX      | OTHER BODY PAIN      | GI TRACT SYMPTOMS      | SWELLING      |  |  |  |  |  |  |
| ONSET |       |  |  |  |  |  |  |  |  |  |  |
| SITE |       |  |  |  |  |  |  |  |  |  |  |
| CHARACTER |       |  |  |  |  |  |  |  |  |  |  |
| RADIATION |       |  |  |  |  |  |  |  |  |  |  |
| ASSOCIATIONS |       |  |  |  |  |  |  |  |  |  |  |
| TIME LINE |       |  |  |  |  |  |  |  |  |  |  |
| EXACERBATING/RELEIVING FACTORS |       |  |  |  |  |  |  |  |  |  |  |
| PAIN SEVERITY /10 |       |  |  |  |  |  |  |  |  |  |  |
| OTHER |       |  |  |  |  |  |  |  |  |  |  |

**Other relevant systemic examination**:

**Dry Mouth:**

Shortened Xerostomia Inventory (SXI); { Thomson et al 2011}=

**PHQ-9=**

**CLINICAL EXAMINATION**:

**General:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE**  | **PALPABLE LYMPH NODES**  | **SWELLING**  | **CRANIAL NERVE FUNCTION**  | **Mouth opening**  | **Muscle tenderness**  | **Salivary gland palpation**  | **Other**  |
|  |  |  |  |  |  |  |  |
| **DATE**  | **Obvious weight loss**  | **Anaemia**  | **Jaundice**  | **Cyanosis**  | **Oedema**  | **Skin lesions**  | **Nails** |
|  |  |  |  |  |  |  |  |

**Intra Oral:**

**Soft tissue examination**:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DATE**  | **CHEEK****L**  **R**  | **TONGUE****DORSAL**  **VENTRAL**  | **TONGUE LATERAL****L R**  | **FLOOR OF MOUTH**  | **PALATE****L**  **R**  | **GINGIVA****L R**  | **Lips** |
|  |  |  |  |  |  |  |  |  |  |  |   |   |

**Dental findings:**

|  |  |
| --- | --- |
| **Date**  |  |
| **Dentition present** |  |
| **Occlusion** |  |
| **Bruxism** |  |
| **Dentures** |  |
| **Implants**  |  |
| **Endodontics** |  |

**PAIN: Description:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date  | palpation  | Temporalis /10L R  | Masseter/10L R  | TMJ /10L R  | Pterygoid L R  |
|       | Extra Oral  |  |  |  |  |  |  |  |  |
|  | Intra Oral  | NA  | NA  |  |  | NA  | NA  |  |  |
|  | Mouth Opening  |  |  |  |  |  |  |  |
|  | Bruxism  |  |  |  |  |  |  |  |
|  | clicking  | NA  | NA  | NA  | NA |  |  | NA | NA |
|  | Other |  |  |  |  |  |  |  |  |

**SUMMARY OF EXAMINATION**

**CLINICAL PHOTOS:**

**SPECIAL INVESTIGATIONS:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DATE  | OPG  | CT  | MRI  | BLOOD TESTS  | BIOPSY  | SALIVA FLOW  | OTHER  |
|       |  |  |  |  |  |  |  |

**SUMMARY OF FINDINGS:**

|  |  |  |
| --- | --- | --- |
| **Date**  |  |  |
| **Complaint:** |  |  |
| **Pain:** |  |  |
| **Mucosal lesions:** |  |  |
| **Xerostomia index** |  |  |
| **Saliva Flow:** |  |  |
| **Imaging:** |  |  |
| **Blood tests** |  |  |
| **PHQ-9 Score** |  |  |
| **Biopsy:** |  |  |

**DIAGNOSIS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date**  |  |  |  |
| **Pain:** | **TMD I** |  | **TMD II** |  | **TMD III** |  |
| **Pain:** |  **Peripheral Neuropathy** |  | **Central Neuropathy** |  | **Mixed** |  |
| **Mucosal lesions:** | **Ulceration** |  | **Autoimmune** |  | **Dysplasia** |  |
| **Saliva Flow:** | **Hyposalivation** |  | **Dyseasthesia** |  | **Disease** |  |
|  **Other:** |  |  |  |

**TREATMENT PLAN :**

1.

**MANAGEMENT:**

**Reviiew**

**Date:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Never****(0)** | **Hardly Ever (1)** | **Occasionally (2)** | **Frequently****(3)** | **Always****(4)** | **Total** |
| **My Mouth feels Dry** |  |  |  |  |  |  |
| **I have difficulty eating dry foods** |  |  |  |  |  |  |
| **My mouth feels dry when eating a meal** |  |  |  |  |  |  |
| **I have difficulty swallowing certain foods** |  |  |  |  |  |  |
| **My lips feel dry** |  |  |  |  |  |  |
| **How often does your mouth feel dry** |  |  |  |  |  |  |
| **TOTAL/20** |  |  |  |  |  |  |

|  |
| --- |
| Over the last two weeks, how often have you been bothered by any of the following problems? |
| Little interest or pleasure in doing things? |  |
| Feeling down, depressed, or hopeless? |  |
| Trouble falling or staying asleep, or sleeping too much? |  |
| Feeling tired or having little energy? |  |
| Poor appetite or overeating? |  |
| Feeling bad about yourself - or that you are a failure or have let yourself or your family down? |  |
| Trouble concentrating on things, such as reading the newspaper or watching television? |  |
| Moving or speaking so slowly that other people could have noticed?Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual? |  |
| Thoughts that you would be better off dead, or of hurting yourself in some way? | Not at allSeveral daysMore than half the daysNearly every day |

**Score= 0-4 ( none); 5-9 (mild); 10-14 (moderate); 15-19 (moderately Severe); 20-27 (severe)**