

PERIODONTAL EXAMINATION & CHARTING FORM

Student Name:

Computer No. :

Patient's Name:

File No.

Age: _____ yrs.

Gender:

Occupation:

Nationality

Marital Status:

Date

Chief Complaint:

Dental History

Medical History

Smoking:

No - Yes (type?, frequency?, how long?)

I. Extra-Oral Examination:

II. Intra-Oral Examination:

I.1. Buccal Mucosa:

I.2. Gingiva:

I.2.a. Color:

I.2.b. Tone (consistency)

I.2.c. Contour

I.2.d. Attached Gingiva

I.3. Mucogingival Defects

Oral Hygiene Habits

◆ *Type of Tooth brush:*

Soft – Medium - Hard

◆ *Brushing Technique*

Horizontal- Vertical –

Circular - Combination

◆ *Interdental Aids*

Yes (type):

No

• *Miswak*

Yes – No

• *Other*

RADIOGRAPHIC EVALUATION

Plaque Retentive Factors:

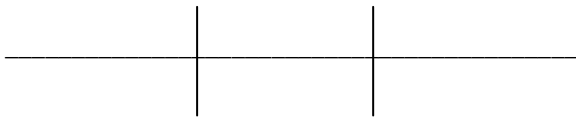
Over-hangs / defective restorations:

Calculus

Caries:

Alveolar Bone Assessment:

Horizontal Bone Loss (%)



Crestal Bone Density

Vertical Defects:

Furcation Radiolucencies:

PDL Width:

Root length/ form/proximity:

Other findings / pathology:

Supervisor's Signature

Date

DIAGNOSIS (OVERALL DENTAL DIAGNOSIS)

PERIODONTAL DIAGNOSIS

PROGNOSIS

Overall:

Individual:

TREATMENT PLAN

Phase I:

Supervisor's Signature

Date

REVALUATION

DEFINITIVE TREATMENT PLAN

Supervisor's Signature

Date

RECALL AND MAINTENANCE

Supervisor's Signature

Date