

Oral Med 526 Clinical Rotation Write-up

STUDENT NAME: _____ CHART #: _____ DATE: _____

Pt's. Age _____ Pt's. Gender: M F Pregnancy status: _____ Not known Not applicable

MEDICAL CONDITIONS (INCLUDE PSYCHOLOGICAL CONDITIONS) **MARK HERE IF NONE**

	CONDITION	POSSIBLE OROFACIAL IMPLICATIONS	DENTAL CARE MODIFICATIONS NEEDED?
1			
2			
3			
4			
5			
6			
7			

Continue next page if necessary.

OPERATIONS/HOSPITALIZATIONS (with relevance for oral health or dental care): **MARK HERE IF NONE**

Type	When	Reason	Dental care impact

Continue next page if necessary.

MEDICATIONS (include prescription, OTC and alternative medications and supplements): **MARK HERE IF NONE**

	Generic name	Strength	Frequency	Reason for taking	Dental care impact?
1					
2					
3					
4					
5					
6					
7					

Continue next page if necessary.

ALLERGIES: **MARK HERE IF NONE**

Medication/substance	Type of Reaction	Severity

Continue next page if necessary.

HABITS/DIETARY CONCERNS **MARK HERE IF NONE**

Substance	Type	Frequency	Impact on Oral Health
Alcohol			
Tobacco			
Other Substance			
Dietary Excess or Deficiency			

Continue next page if necessary.

Continue on next page.....

