

ORAL HEALTH ASSESSMENT

Name _____ ID No.(if applicable) _____
 DOB _____ Gender _____ Date of Oral Assessment _____
 Assessment performed by _____

Extra Oral Exam

Visible facial asymmetry or glandular enlargement: ___ yes ___ no

Lymph node exam

Enlarged or tender ___ yes ___ no

If yes, specify location(s): _____

Skin or lip sores: ___ yes ___ no

If yes, specify: _____

Intra Oral Exam

Soft Tissues	Smooth, pink	Bleeding	Ulcerated	Red or white patch	Pigmented lesion
Lips					
Tongue					
Gums					
Cheeks					
Floor of mouth					
Roof of mouth					

Teeth: Upper jaw ___ yes ___ no Lower jaw ___ yes ___ no

Stained ___ Decayed ___ Broken or chipped ___

Dentures: ___ yes ___ no

If yes, check all that apply:

___ Full Upper ___ Partial Upper ___ Broken Upper

___ Full Lower ___ Partial Lower ___ Broken Lower

___ Dentures worn full-time ___ Dentures worn when sleeping

___ Dentures worn only when eating ___ Dentures removed for eating

___ Dentures appear not clean ___ Dentures have owner's name or ID no.

Breath: ___ Normal odor ___ Foul odor

Saliva: ___ Mouth appears moist ___ Mouth appears dry

Does the patient have any complaints about oral, teeth or denture discomfort:

___ yes ___ no If yes, specify: _____

Examination recommendations/comments: _____

