Periodontal assessment forms

An essential element in the patient treatment plan

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When examining a patient with significant periodontal disease, it is essential that you utilize properly designed charts. An accurate record of the patient's "baseline" periodontal status is critical in order to be able to diagnose, design a treatment plan and monitor the patient's condition. Similarly, a customized chart is required for those patients who are on a periodontal maintenance program. Subtle changes in the periodontium are more quickly diagnosed when comparing accurate periodontal measurements (i.e. pockets, mobilities etc.). Proper charts that facilitate comparison of measurements over many appointments are far better than "eyeballing" the patient's status.

It is not my suggestion that every patient in general practice be assessed using the forms I describe. Rather, I do suggest all patients be *carefully* screened for periodontal disease. If, in fact, disease is diagnosed, and proper periodontal treatment is indicated, it *must* be preceded by thorough examination, diagnosis and treatment planning. If the situation is beyond the capability of the general practitioner, referral to a periodontist is needed.

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We are pleased to present the first publication of this article, written especially for *Oral Health*.

In this article, I will discuss the components of two periodontal forms that I use. The first is my "Active Chart", used initially and throughout active therapy. The second is my "Periodontal Maintenance Record". It is not within the scope of this particular article however, to discuss the:

a) technique of the examination and consultation;
b) analysis of the information gathered;
c) diagnosis, prognosis, treatment planning;
d) treatment techniques;
e) guidelines for referral; and
f) guidelines for establishing a proper maintenance program.

The components of a periodontal assessment form suitable for patients initially (i.e. "active chart") include:

1) *Chief Complaints* (Figure 1). It is often easy to become so involved with the details of a complex case that we forget to address the patient's main reasons for seeking treatment.

2) *Medical, Dental History* (Figure 1). A detailed medical and dental history are best documented on a separate form. Significant findings should be transferred onto a section of the periodontal assessment form for easy reference. An abbreviation of WNL (within normal limits) that is checked off, assures that the medical has been done.

3) *Habit History* (Figure 1). Incorporate a section in your chart to make note of any parafunctional habits your patient has that may be of significance. You may find it convenient to use a check-list type of format.

4) *Oral Examination* (Figure 2). As with the habit history section, a check-list format saves time and writing. Certain abbreviations such as WNL (within normal limits), and M.A.G. (minimal attached gingiva) are useful.

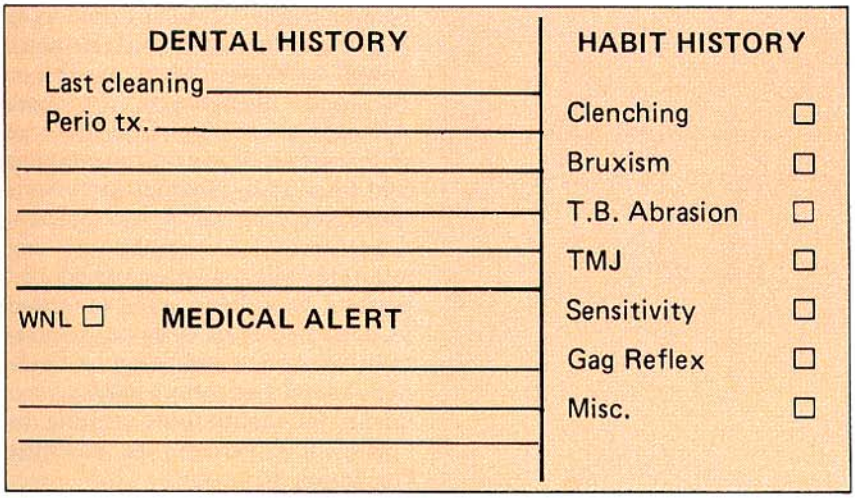

Figure 1. Chief complaint, dental history, habit history and medical alert.

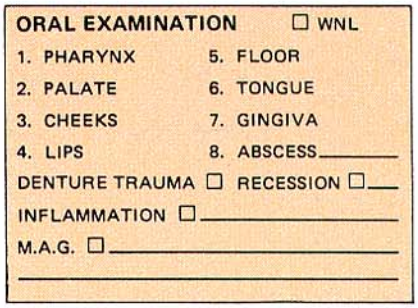

Figure 2. Oral examination.

ORAL HYGIENE

Date / /

	MIN.	MOD.	HEAVY	SUPRA	SUB
PLAQUE	☐	☐	☐	☐	☐
CALCULUS	☐	☐	☐	☐	☐
STAIN	☐	☐	☐		

PRE TX AIDS: Bx , Fx ,

DATE	AIDS	PROGRESS / AREAS MISSED

RESTORATIVE/RADIOGRAPHIC FINDINGS

1. CARIES:
2. P.A. AREAS:
3. POOR MARGINS:
4. FURCA. INV.:
5. IMPACTED TEETH / ROOTS:
6.
7.

Figure 3. Oral hygiene. Restorative — radiographic findings.

OCCLUSAL ANALYSIS

1. ARCH. RELATIONS
2. OVERBITE
3. OVERJET
4. VERT. DIM.
5. SLIPS
6. MIGRATION
7. FREMITUS
8. FACETS
9. C.R.
10. R.L.
11. L.B.
12. L.L.
13. R.B.
14. P.
15. X-BITE
16. APPLIANCE – HAWLEY NIGHT GUARD
17. OCC. ADJ.

DATE COMPLETED / /

	Gross	Cent.	Lat.	Pro.
EQUILIBRATION COMPLETED	☐	☐	☐	☐

Figure 4. Occlusal analysis.

5) *Oral Hygiene Status* (Figure 3). Numerous scientific studies have emphasized the critical importance of the patient's oral hygiene in maintaining periodontal health. This section is extremely important and deserves your attention. You should document:

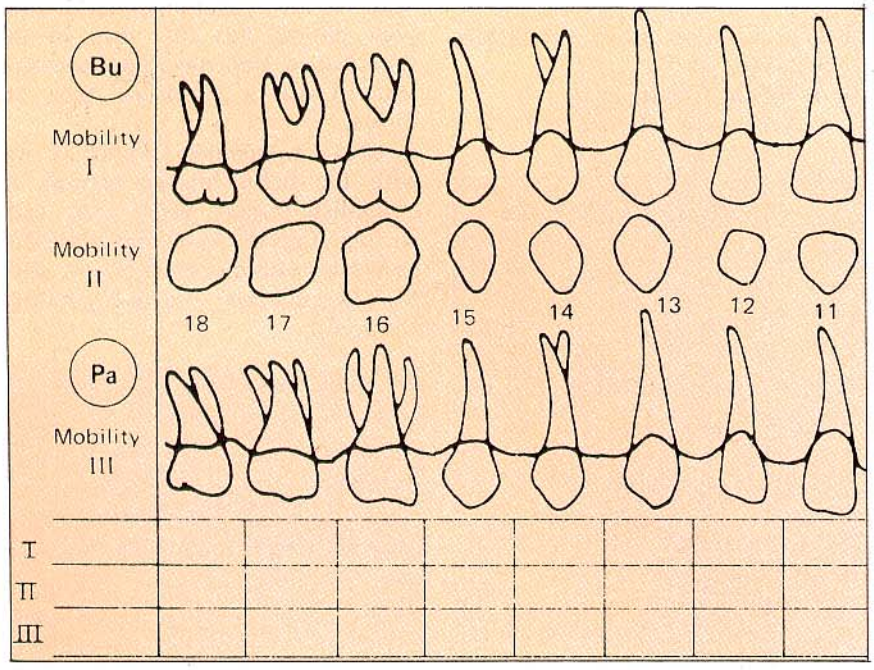

Figure 5. Grid and tooth diagrams (representative of actual chart size).

a) the quantity and location of local deposits;
b) the current oral hygiene aids in use and the frequency with which they are employed;
c) an assessment over a *series* of several appointments of the patient's progress and any changes in the types of aids being used.

6) *Radiographic Findings* (Figure 3). Significant findings should be noted as well as "drawn" where possible on the tooth diagrams in the chart. Although not strictly within the scope of this article, it is worth mentioning that when analyzing radiographs one must keep in mind the inherent limitations. Radiographs are not accurate indicators of a) periodontal pockets, b) inflammation, c) treated vs. untreated cases, d) mobility and e) radicular bone morphology. As well, periodontal patients require a good quality full mouth series utilizing the "parallelling system" to minimize angulation distortion.

7) *Occlusal Analysis* (Figure 4). The

DIAGNOSIS/PROBLEMS	PROGNOSIS	RE-EVALUATION DATE ___ / ___ / ___
1.	OVERALL Mx: Md:	OH:
2.	GOOD	CALCULUS: MINIMAL ☐ MODERATE ☐ ABUNDANT ☐
3.	FAIR	RESIDUAL AREAS:
4.	GUARDED	
5.	QUEST.	
6.	POOR	
7.		
8.	HOPELESS	

PERIODONTAL TREATMENT PLAN

- ☐ 1. EXAM, FMX, DUP. FMX, PHOTOS, MODELS, CONSULT
- ☐ 2. OHI ☐ RE-OHI ☐ FILM ☐ HANDOUTS ☐
- ☐ 3. S/RP: _____
- ☐ 4. REEV _____
- ☐ 5. RX: _____
- ☐ 6. OCC ADJ ☐ HAWLEY NIGHT GUARD ☐
- ☐ 7. SURGICAL FLAP ┼┼ MUCO ┼┼
- ☐ 8. ALTERNATIVES _____
- ☐ 9. EXTRACTIONS INITIAL ┼┼ POST ┼┼
- ☐ 10. INTERIM RESTORATIVE _____
- ☐ 11. FINAL RESTORATIVE _____
- ☐ 12. MAINTENANCE _____

(☑ COMPLETED TX.) (CIRCLE TX. TO BE DONE)

COMPLETED ACTIVE TREATMENT

SCALING CURETTAGE ┼┼ FLAP SURGERY ┼┼ MUCOGINGIVAL SURGERY ┼┼

OTHER

PERIODONTAL MAINTENANCE PLAN

1. INITIAL RECALL IN _____ MONTHS
2. RECALL INTERVAL IS _____ MONTHS
3. ALL HERE ☐ ALL AT G.P. ☐ PT. REQUEST ☐
4. ALTERNATING: HERE ____ ____ ____ ____
   AT GP ____ ____ ____ ____
5. PERIO REEV. IN _____ MONTHS TO
   CONSIDER NEED FOR _____

Figure 6. Diagnosis/problems, prognosis, re-evaluation, periodontal treatment plan, completed active Tx, restorative suggestions, periodontal master.

role of occlusion in the progression of periodontitis is controversial and thus so are the indications for occlusal adjustment. All periodontal examinations should include a complete occlusal analysis. The examination can be easily carried out following an abbreviated list as outlined in Figure 4 (*C.R.* – centric relation, *R.L.* – right lateral excursion, *R.B.* – right balancing interferences, *P.* – protrusive excursion contacts, *X-Bite* – teeth in crossbite etc.). Your analysis should also include indications for appliance therapy such as a hawley anterior bite plate or a night guard.

8) *Circuit Charting* (Figure 5). Your assessment form should have a large section devoted to diagrams of the teeth illustrating facial, occlusal and oral surfaces. In conjunction with these diagrams there should be a "grid" with sufficient space to accommodate three series of pocket measurements (three sets of mobility

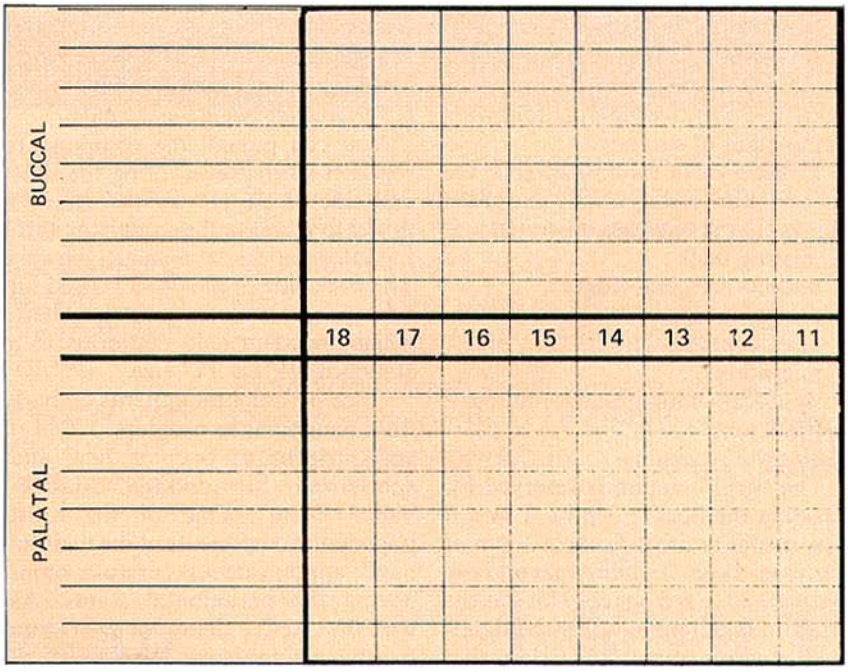

Figure 7. Periodontal maintenance form — front.

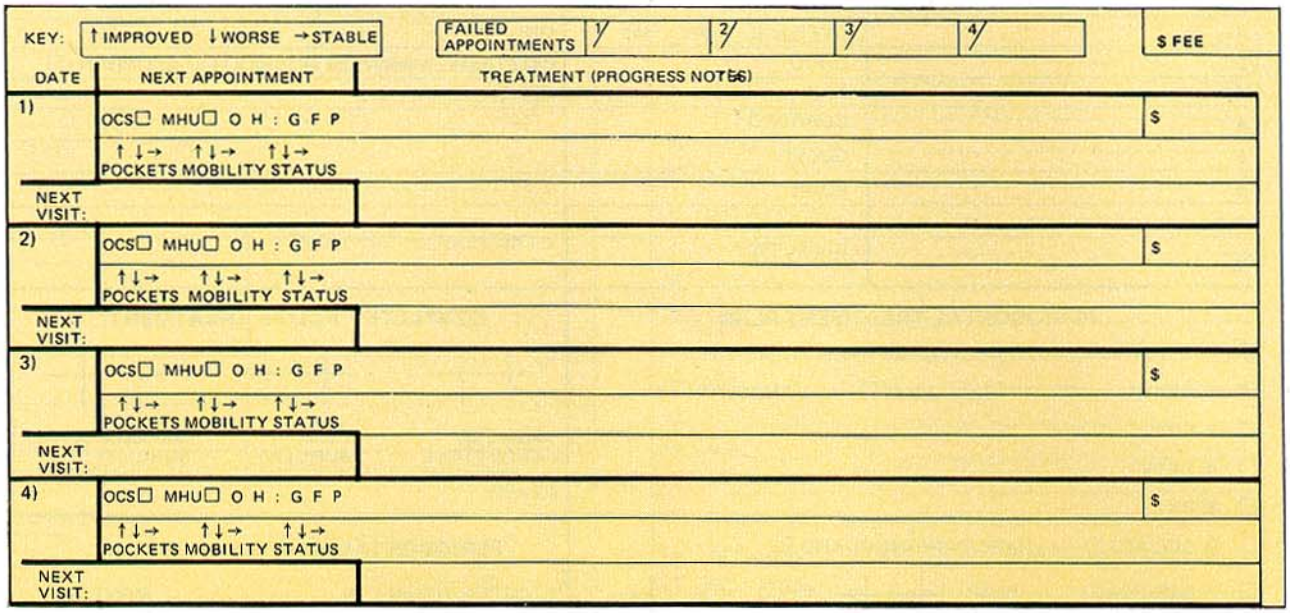

Figure 8. Periodontal maintenance form — back.

measurements corresponding to the pocket measurements, i.e. taken at the same time, can be accommodated within the three different views of the tooth diagrams). The circuits should be timed to coincide with:

a) the initial periodontal examination;
b) the re-evaluation, which should be carried out two to three months following the completion of initial periodontal therapy.

If surgery has been done, then the third set of measurements can be done two to three months following completion of surgery.

In the area of tooth diagrams, the following are examples of some of the things that should be illustrated:

- missing teeth
- uneven marginal ridges
- plunger cusps
- open contacts
- migrations
- significant radiographic findings
- furcations
- gingival recessions

The "grid" section is reserved for charting the pocket depths. I find it very useful to chart pockets 3 mm or less in lead pencil while 4 mm or more are marked in red pencil. This has the effect of highlighting the more significant measurements and works well if you want to illustrate the problem areas to your patient during your consultation.

9) *Figure 6* – Your assessment form should also have sections on: a) *diagnosis*, b) *prognosis*, of the teeth overall and individually, c) *treatment plan*, incorporating a properly sequenced multi-disciplined approach, d) *completed active treatment* using a "check off" system in order to have a convenient reference, e) *re-evaluation* – findings indicating the oral hygiene and the overall status, as well as areas of residual calculus, and f) *periodontal maintenance plan*.

You can put all the components together so that everything fits onto one side of an 11″ × 17″ chart. I prefer to visualize the complete charting information "at a single glance". The back side of the chart is used for your progress notes and the chart, when folded in half, conforms to a standard 8½″ × 11″ size.

Once periodontal patients embark on a maintenance program, I find it very helpful to open a new and specialized "Periodontal Maintenance Form". One of the most important components of the maintenance appointment is carefully monitoring the periodontal status. As with the "Active Chart" or even more so, the maintenance form must be organized in a manner that facilitates a comparison of periodontal measurements over a series of many appointments. Figure 7 demonstrates the format where eight complete sets of measurements can be carried out so that any single measurement can be conveniently monitored over time. The back side of this form (Figure 8) is reserved for your progress notes. In the interest of saving time, space and writing, certain other essential components of your maintenance appointment can be pre-printed in abbreviated form. For example, *MHU* – Medical History Update, *OCS* – oral cancer screen, *OH: GFP* – Oral Hygiene status, good, fair or poor; (↑↓→) far improved (↑) worse (↓) or stable (→) (in reference to pocket depths, mobility and overall periodontal status).

The implementation of a periodontal program in your practice encompasses many components and proper documentation is one of the most important. Those who claim that they are monitoring their patient's periodontal status are at times not adequately fulfilling their responsibility if there is incomplete documentation.

Acknowledgement
I wish to acknowledge the help of Dr. L. Schwartz in designing the assessment forms presented in this article.