

History and Clinical Examination

General Guidelines

The purpose of the history and clinical examination is to observe and record the pertinent information, past and present, necessary to arrive at a rational diagnosis and treatment plan.

The elements of the history and clinical examination are the same, regardless of the dental service to be performed. These elements include a general physical evaluation in addition to a dental evaluation.

The dental history and clinical examination should focus on the problem or complaint presented by the patient. It should also include a general survey of the oral cavity and related structures.

The dental history and clinical examination records, or charts, should include a tooth chart indicating the oral condition as to:

- Caries
- Restorations, defective or acceptable
- Fixed and removable prostheses
- Missing teeth
- Endodontic status
- Periodontal status, based on minimal probing and screening. Existing conditions including location and measurement of pockets, etiologic factors, mobile teeth, occlusal trauma
- Occlusal status
- Description of the general health and appearance of the neck, lips, gingiva, oral mucosal membranes, tongue, pharynx; evidence of attrition and erosion, bruxism or clenching, harmful habits; and attitude
- Incipient and other types of lesions

The general medical history should contain information pertaining to:

- General health and appearance
- Systemic disease; such as cardiac condition, history of rheumatic fever, diabetes, hepatitis
- Allergies and sensitivity to drugs
- Reaction to dental anesthetics
- Present medication and present treatment

- Bleeding problems
- Nervous disorders
- Any other pertinent information

The medical history should allow for a thorough physical evaluation of the patient's physical and emotional ability to tolerate dental procedures safely, as well as a general evaluation of his health.

Based upon review of the medical history, and completion of the physical evaluation, the physical status of the patient may be graded in accordance with the American Society of Anesthesiologists' classification:

Class 1: A normal health patient for an elective procedure

Class 2: A patient with a mild systemic disease

Class 3: A patient with severe systemic disease that limits activity but is not incapacitating

Class 4: A patient with an incapacitating disease that is a constant threat to life

Class 5: A moribund patient who is no expected to survive 24 hours without the operation

The medical and dental history which is taken initially should be updated periodically. Baseline observations should be recorded for comparison with future observations as the patient returns for periodic examination and treatment.

The following quality-evaluation criteria should be considered merely as AIDS for the discrimination between the four ratings for each characteristic. The determination of the four ratings for each characteristic. The determination of the rating of any given dental service is dependent upon the sound JUDGMENT of the peer review examiners.

HISTORY AND CLINICAL EXAMINATION

QUALITY EVALUATION RATING SYSTEM		
	Rating	Operation Explanation
S A T I S F A C T O R Y	R Range of Excellence ROMEIO Code: R Call: Romeo	The history and examination provide all necessary information for the development of a rational diagnosis and treatment plan.
	S Range of Acceptability SIERRA Code: S Call: Sierra	The history and examination provide sufficient information for diagnosis and treatment plan but one or more features of the history and/or examination deviate from the ideal.
N O T S A T I S F A C T O R Y	T Not Acceptable Validity Questionable TANGO Code: T Call: Tango	The history and examination, as recorded, do not provide the information necessary for the development of a rational diagnosis and treatment plan but the deficiencies do not appear to be harmful or dangerous for the dental or general health of the patient.
	V Not Acceptable Information Inadequate VICTOR Code: V Call: Victor	The history and examination are inadequate for establishment of whether potential harmful or dangerous conditions are present.

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HISTORY AND CLINICAL EXAMINATION

QUALITY EVALUATION CRITERIA AND ABBREVIATIONS			
Code	History	Code	Clinical Examination
	A thorough history has been taken initially, including previous radiographs, and updated regularly (dates indicated). (Refer to General Guidelines.)		A thorough examination has been conducted and recorded. (Refer to General Guidelines.)
SUD	A fairly complete dental/medical history has been taken initially, but evidence is missing that it has been updated periodically.		A fairly thorough clinical examination has been conducted and items that are necessary for diagnosis and treatment planning are included. Conditions that clearly deviate from normal health and appearance are recorded, but the clinical examination record is incomplete .
SCM SRC	A fairly complete dental/medical history has been taken initially, but one or more items have not been completed or recorded .	SIM	
TGL TSS TAL TSN TMD TTR TBL	Dental/medical history has been taken but is inadequate. Information is missing in regard to general health, or systemic diseases, or allergies and sensitivity , or present medication and treatment or bleeding problems.	TRC	There is no direct record of the clinical examination, but the treatment plan indicates that potentially harmful or dangerous conditions were detected.
VRC	No record exists to show that a dental/medical history was taken initially or during subsequent treatments.	VCAR VPER VPA VFR VTA VPAT	Harmful or dangerous conditions were not detected in the clinical examination. There is evidence of large carious lesions, periodontal pockets and bone loss, periapical pathology, undetected fractures and traumas , and/or undetected tumors or other pathological conditions.

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