|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | | | | | | | | **Date:** |  |
| **Is the service user able to use a tooth brush?** | | | Yes | | | No | If “No” what is the reason? | | | |
| **Is the service user able to press the toothpaste alone?** | | | Yes | | No | | If “No” what is the reason? | | | |
| **Favourite brand of toothpaste:** | | | | | | | |  | | |
| **Preferred type of toothbrush** | | | | | | | | Manual Battery | | |
| **How many times does the service user wish to have their teeth cleaned a day?\* *Brushing twice a day is recommended*** | | | | | | | |  | | |
| **Does the service user have dentures?** | | | Yes | No | | | Additional Information: | | | |
| **Are dentures clean?** | | | Yes | No | | |  | | | |
| **Are dentures plastic?** | | | Yes | No | | |  | | | |
| **Are dentures metal** | | | Yes | No | | |  | | | |
| **Does the service user have:** | | None Full set Bottom Top | | | | | | | | |
| **When are the dentures worn?** | | All day Meal times only Not worn | | | | | | | | |
| **Are the dentures kept in a pot?** | | Yes No | | | | | | | | |
| **Are the lips** | | Soft Dry Cracked | | | | | | | | |
| **Does the service user have cold sores?** | | Yes No | | | | | | | | |
| **Is there any halitosis breath (bad breath)?** | | Yes No | | | | | | | | |
| **Does the tongue look pink?** | | Yes No | | | | | | | | |
| **Does the tongue move freely?** | | Yes No | | | | | | | | |
| **Are the gums** | | Pink Red Bleeding when brushed | | | | | | | | |
| **Overall oral condition** | | Healthy Mild dysfunction  Moderate dysfunction Severe dysfunction | | | | | | | | |
| **Are there any mouth ulcers, lumps or white patches? Please detail** | |  | | | | | | | | |
| **Does the service user require a referral to dentist?** | | Yes No | | | | | | | | |
| **When was the last known visit to the dentist?** | | Date…………………………………………….. | | | | | | | | |
| **Does the service user have a preferred dentist?**  **(If yes, give details)** | | Yes No | | | | | | | | |
| **Any other relevant information** | |  | | | | | | | | |
| **Date to be reviewed:** | |  | | | | | | | | |
| **Completed by ; Name** | |  | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
| |  | | --- | | Teeth Missing: | |  | | Dentures: | | Upper  Lower  Part\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   [Image result for dental layout of teeth](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwiVneyQ4PbSAhViBcAKHX_YBw0QjRwIBw&url=http://www.dentalserviceshungary.com/index.cfm/contact-us/dental-implants-quotation-request/&bvm=bv.150729734,d.ZGg&psig=AFQjCNFhKZ6MKHl4ZK3ZH0QYwumNGukhjg&ust=1490704137166805) | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date |  |  |  |  |  |  |  | Signed |
| Brushing | | | | | | | | |
| Upper teeth |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Lower teeth |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Dentures | | | | | | | | |
| Cleaned | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No |  |
| Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No | Yes  No |  |
| Other | | | | | | | | |
| any ulcers or bleeding (include placement) |  |  |  |  |  |  |  |  |
| Any other comments |  |  |  |  |  |  |  |  |
| Signed |  |  |  |  |  |  |  |  |