# Presentation of a model of periodontal clinical record

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**Abstract**

**Introduction:** The clinic form is an essential tool for the execution of any periodontal procedure. Its finality is to obtain and record as much information as possible about the patient's general and oral state of health, besides storing records of all executed procedures since initial appointment until the treatment conclusion. **Objective:** The purpose of this work is to emphasize the importance of the periodontal clinic form and propose a guidance model for professionals and institutions on the elaboration of their own clinical forms. **Methods:** Through the analysis of the data contained on clinical forms of several institutions and study of the main articles related to the subject it was created an specific model of clinical form for Periodontics.

**Keywords:** Clinic form. Periodontics. Periodontitis. Data analysis.

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## Introduction

The periodontal form, present on dental clinical records, was defined as a document in which it can be recorded and kept all information regarding the patient, from his/her systemic health condition to clinical particularities, that will guide his/her treatment needs.[1] This documentation, based on the individual response of each patient, helps to improve the diagnosis accuracy, inform the correct prognosis and elaborate an appropriate treatment plan.[2] The periodontal clinic form is one of the components of the dental record. Besides the clinical forms, it is also part of the dental record: Prescriptions, recommendations, certificates, complementary exams, radiographs, photographs, models and other documents, that must be correctly executed and stored by the professional.[3] Recording data becomes essential especially to follow the treatment development, for revaluation of each phase and to follow the case in the long term.[4] Many professionals, although perform an appropriate technical work, end up not recording correctly the information obtained before, during and after treatment, by negligence or, most of the time, because they don't have an embracing clinical form or of easy fill out. It is important to emphasize that the dental documentation, when correctly done, shows technical efficiency from the professional in his practice, besides, it can be used as evidence in eventual civil suit, criminal procedures, ethical process, and as consultation tool in cases of human identification.[5] The present study has as objective to introduce an specific periodontal clinical form, in a simple, concise and complete way that allows the correct elaboration of the patient's treatment and that facilitates restoring all relevant data in every appointment, providing a model that can guide professionals or educational institutions on the elaboration of their own clinical forms.

## Material and Methods

For the elaboration of a periodontal clinic form model, it was performed a study of the main articles related to the subject and an investigation of the data contained on periodontal forms used in some graduation courses in Brazil and abroad.[6] The personal, medical and dental questioning as well as periodontal charts and procedure forms were analyzed and compared with one another. All relevant data were collected and new data were introduced for the elaboration of a new periodontal clinic form model, updated and integrated with the medical specialties. The form is constituted of:

### *Term of commitment*

The negligence on anamnesis characterize professional mistake, and may subject to ethical and legal sanctions. Therefore, professionals must explain to their patients about the importance of having access to all clinical information for the sake of their own health and success of the dental therapy.[7] In this form model, the patient is responsible for the veracity of the information and authorize the use of the material for didactic purposes and research, becoming particularly important for the clinical forms of educational institutions or research centers (Fig 1).

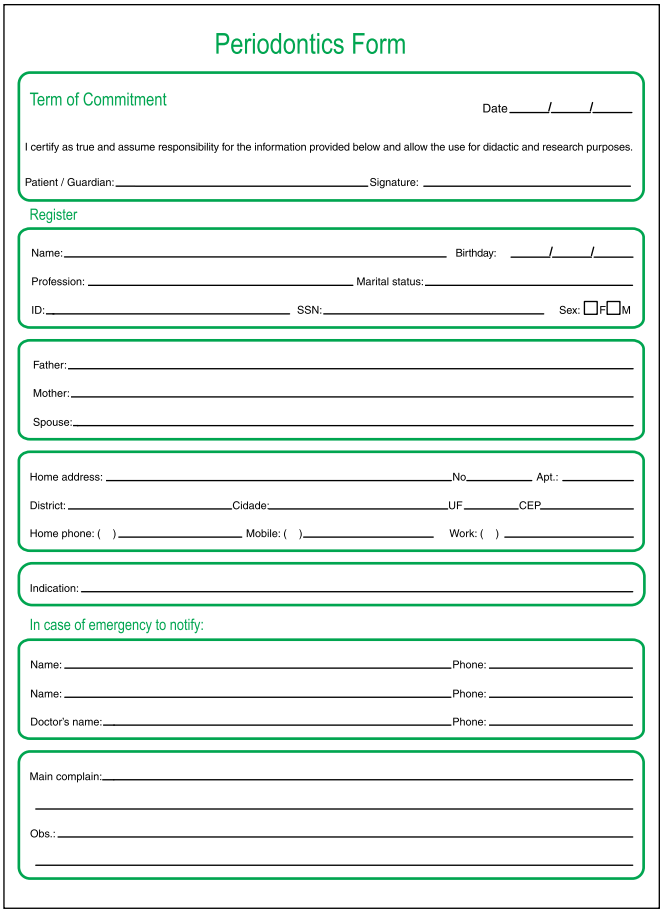
### *Register*

This item contains the patient's data usually found in most forms: full name, date of birth, profession, civil status, ID, SSN, gender, filiation, home address, contact phone numbers.[8] Besides, data related to the name of the spouse or close people are fundamental to secondary contact in case of complications during treatment. The name of the doctor is also necessary to allow access to further information about the state of health, prescription of medicines or availability of certain procedures (Fig 1).

### *Chief complaint*

The chief complaint is a key component. It will determine the beginning of the intraoral exam, for it is the main objective of the appointment for the patient.[9,10]

The correct comprehension of the patient's complaint facilitates the good relationship between patient and professional and his satisfaction with the treatment. Obviously, the professional must expound other findings from the intraoral exam that are, many times, more important than the chief complaint reported and orientate the patient regarding all other necessary procedures that must be prioritized so that it is possible to effectively promote oral health (Fig 1).[11] On the "Observations" item below the "Chief complaint" the professional can included other information such as: difficulty to express or communicate about the chief complaint from the patient, degree of concern about the reported event and other relevant information.


Periodontics Form

Term of Commitment

Date ____/____/____

I certify as true and assume responsibility for the information provided below and allow the use for didactic and research purposes.

Patient / Guardian: _____ Signature: _____

Register

Name: _____ Birthday: ____/____/____

Profession: _____ Marital status: _____

ID: _____ SSN: _____ Sex: ☐F ☐M

Father: _____

Mother: _____

Spouse: _____

Home address: _____ No. _____ Apt.: _____

District: _____ Cidade: _____ UF _____ CEP _____

Home phone: ( ) _____ Mobile: ( ) _____ Work: ( ) _____

Indication: _____

In case of emergency to notify:

Name: _____ Phone: _____

Name: _____ Phone: _____

Doctor's name: _____ Phone: _____

Main complain: _____

Obs.: _____

**Figure 1** - Term of commitment, register and chief complain.

### *Medical history*

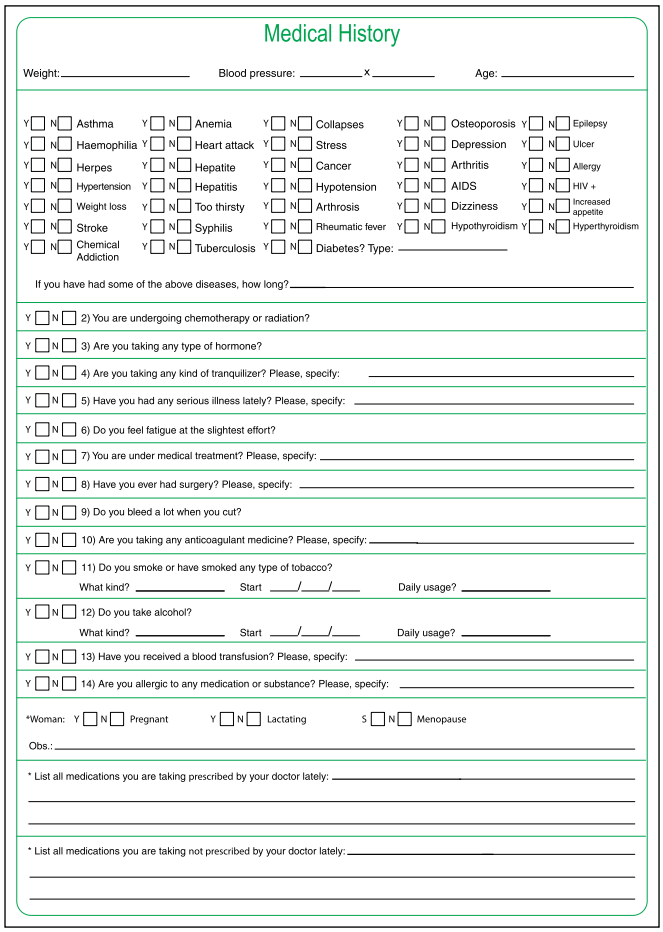
The performance of the medical history investigation provides support so the surgeon dentist correlates the systemic state of the patient with his dental history, providing relevant information for the clinical diagnosis and elaboration of the treatment plan associating them to medical specialties.[12] As the periodontal disease etiology is multifactorial, diseases or systemic alterations can directly affect the host compromising his immune response, accelerating or increasing the progression and tissue destruction caused by the disease. The same way, the periodontal disease may cause some systemic alterations as cardiopathy, chronic pulmonary alteration among other things.[13-18] It is important to know the relation of the medication used by the patient, either for the possibility of interaction with others eventually prescribed or for alterations in the oral cavity and on periodontal tissues that it may cause.[17] On the presented survey there is a differentiated space for prescribed and non-prescribed medication. It is important to emphasize that the intake of medication without the prescription of a professional is a fact very commonly found and it can lead to complications and cause interference on the treatment, if not reported. Any cases of allergy must me recorded, including food, drugs or dental material sensibility. For women, it is important to record situations characterized by hormonal alteration such as puberty, menstrual cycle, pregnancy, menopause or the use of contraceptive.[18] The medical history of this form was carefully elaborated aiming to obtain as much information as possible regarding the patient's current and previous general health state, to allow a safe and integrated clinical management with his condition (Fig 2).

### *Dental history*

The suggested survey is composed of direct questions that aim to record all data related to habits of hygiene, parafunctional, periodontal problems such as gingival mobility and bleeding, reactions to anesthesia, complications in previous dental treatments and performance of treatments from other specialties[19,20] (Fig 3). These data are import so the surgeon dentist has an overview of the patient's oral health condition or, at least, of the perception that the patient has regarding his own oral health.

### *Examiner's comments*

This area located right below the Dental history, allows the addition of extra data collected from the dental or medical history, besides others impressions from the professional that can assist on the diagnosis, planning and execution of the treatment, such as socioeconomic aspects, motivation, expectation of cooperation, intellectual capacity of comprehension of the disease or the treatment or other complementary information collected on the dialogue with the patient and not specified in other areas (Fig 4). This area is also used for that


Medical History

Weight: _____ Blood pressure: _____ x _____ Age: _____

Y ☐ N ☐ Asthma Y ☐ N ☐ Anemia Y ☐ N ☐ Collapses Y ☐ N ☐ Osteoporosis Y ☐ N ☐ Epilepsy
Y ☐ N ☐ Haemophilia Y ☐ N ☐ Heart attack Y ☐ N ☐ Stress Y ☐ N ☐ Depression Y ☐ N ☐ Ulcer
Y ☐ N ☐ Herpes Y ☐ N ☐ Hepatite Y ☐ N ☐ Cancer Y ☐ N ☐ Arthritis Y ☐ N ☐ Allergy
Y ☐ N ☐ Hypertension Y ☐ N ☐ Hepatitis Y ☐ N ☐ Hypotension Y ☐ N ☐ AIDS Y ☐ N ☐ HIV +
Y ☐ N ☐ Weight loss Y ☐ N ☐ Too thirsty Y ☐ N ☐ Arthrosis Y ☐ N ☐ Dizziness Y ☐ N ☐ Increased appetite
Y ☐ N ☐ Stroke Y ☐ N ☐ Syphilis Y ☐ N ☐ Rheumatic fever Y ☐ N ☐ Hypothyroidism Y ☐ N ☐ Hyperthyroidism
Y ☐ N ☐ Chemical Addiction Y ☐ N ☐ Tuberculosis Y ☐ N ☐ Diabetes? Type: _____

If you have had some of the above diseases, how long? _____

Y ☐ N ☐ 2) You are undergoing chemotherapy or radiation?
Y ☐ N ☐ 3) Are you taking any type of hormone?
Y ☐ N ☐ 4) Are you taking any kind of tranquillizer? Please, specify: _____
Y ☐ N ☐ 5) Have you had any serious illness lately? Please, specify: _____
Y ☐ N ☐ 6) Do you feel fatigue at the slightest effort?
Y ☐ N ☐ 7) You are under medical treatment? Please, specify: _____
Y ☐ N ☐ 8) Have you ever had surgery? Please, specify: _____
Y ☐ N ☐ 9) Do you bleed a lot when you cut?
Y ☐ N ☐ 10) Are you taking any anticoagulant medicine? Please, specify: _____
Y ☐ N ☐ 11) Do you smoke or have smoked any type of tobacco?
What kind? _____ Start ____/____/____ Daily usage? _____
Y ☐ N ☐ 12) Do you take alcohol?
What kind? _____ Start ____/____/____ Daily usage? _____
Y ☐ N ☐ 13) Have you received a blood transfusion? Please, specify: _____
Y ☐ N ☐ 14) Are you allergic to any medication or substance? Please, specify: _____

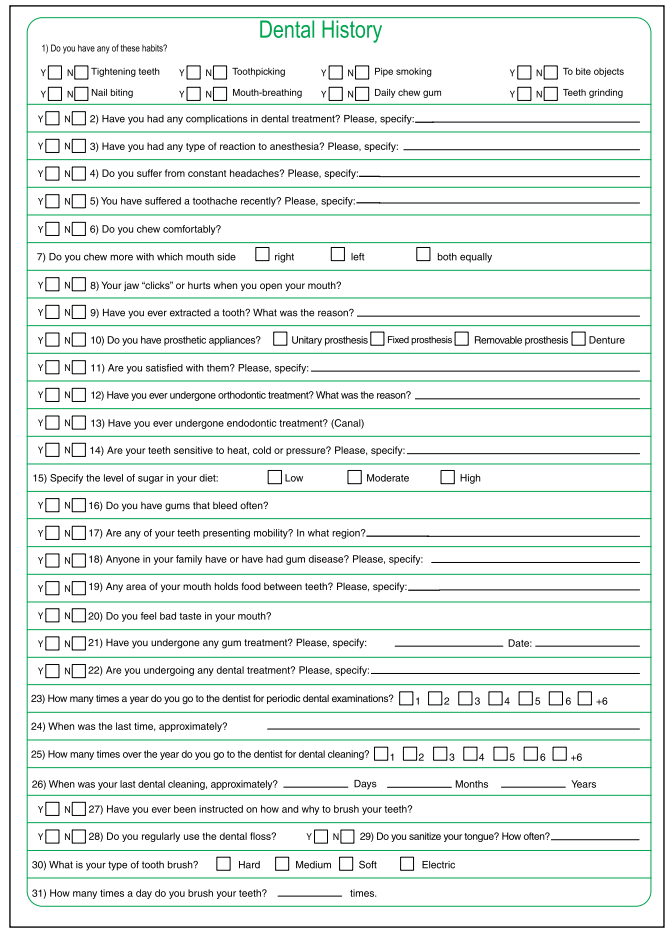
*Woman: Y ☐ N ☐ Pregnant Y ☐ N ☐ Lactating S ☐ N ☐ Menopause

Obs.: _____

* List all medications you are taking prescribed by your doctor lately: _____

* List all medications you are taking not prescribed by your doctor lately: _____

**Figure 2** - Medical history.


Dental History

1) Do you have any of these habits?

Y ☐ N ☐ Tightening teeth Y ☐ N ☐ Toothpicking Y ☐ N ☐ Pipe smoking Y ☐ N ☐ To bite objects
Y ☐ N ☐ Nail biting Y ☐ N ☐ Mouth-breathing Y ☐ N ☐ Daily chew gum Y ☐ N ☐ Teeth grinding

Y ☐ N ☐ 2) Have you had any complications in dental treatment? Please, specify: _____
Y ☐ N ☐ 3) Have you had any type of reaction to anesthesia? Please, specify: _____
Y ☐ N ☐ 4) Do you suffer from constant headaches? Please, specify: _____
Y ☐ N ☐ 5) You have suffered a toothache recently? Please, specify: _____
Y ☐ N ☐ 6) Do you chew comfortably?
7) Do you chew more with which mouth side ☐ right ☐ left ☐ both equally
Y ☐ N ☐ 8) Your jaw "clicks" or hurts when you open your mouth?
Y ☐ N ☐ 9) Have you ever extracted a tooth? What was the reason? _____
Y ☐ N ☐ 10) Do you have prosthetic appliances? ☐ Unitary prosthesis ☐ Fixed prosthesis ☐ Removable prosthesis ☐ Denture
Y ☐ N ☐ 11) Are you satisfied with them? Please, specify: _____
Y ☐ N ☐ 12) Have you ever undergone orthodontic treatment? What was the reason? _____
Y ☐ N ☐ 13) Have you ever undergone endodontic treatment? (Canal)
Y ☐ N ☐ 14) Are your teeth sensitive to heat, cold or pressure? Please, specify: _____
15) Specify the level of sugar in your diet: ☐ Low ☐ Moderate ☐ High
Y ☐ N ☐ 16) Do you have gums that bleed often?
Y ☐ N ☐ 17) Are any of your teeth presenting mobility? In what region? _____
Y ☐ N ☐ 18) Anyone in your family have or have had gum disease? Please, specify: _____
Y ☐ N ☐ 19) Any area of your mouth holds food between teeth? Please, specify: _____
Y ☐ N ☐ 20) Do you feel bad taste in your mouth?
Y ☐ N ☐ 21) Have you undergone any gum treatment? Please, specify: _____ Date: _____
Y ☐ N ☐ 22) Are you undergoing any dental treatment? Please, specify: _____
23) How many times a year do you go to the dentist for periodic dental examinations? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐+6
24) When was the last time, approximately? _____
25) How many times over the year do you go to the dentist for dental cleaning? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐+6
26) When was your last dental cleaning, approximately? _____ Days _____ Months _____ Years
Y ☐ N ☐ 27) Have you ever been instructed on how and why to brush your teeth?
Y ☐ N ☐ 28) Do you regularly use the dental floss? Y ☐ N ☐ 29) Do you sanitize your tongue? How often? _____
30) What is your type of tooth brush? ☐ Hard ☐ Medium ☐ Soft ☐ Electric
31) How many times a day do you brush your teeth? _____ times.

**Figure 3** - Dental history.

alterations of data from medical and dental history, reported in return visits after significant period of time, can be updated, adding them without having to fill out another form. There are specific spaces to record the updates dates.

### *Complementary exams*

Among the complementary exams that may assist on the diagnosis, the radiographs are one of the most frequently required.[21,22] Regarding microbiological tests, they can be requested to assist on specific identification of pathogenic microorganism in the sulcus. These tests provide information that can guide the clinician on the determination of when or which antimicrobial agent could particularly provide a therapeutic benefit to the patient.[23] Laboratorial tests such as hematological analysis (glycemia, clotting time, platelet count), immunoassay and hormonal test are extremely important to assist the management of patients during the treatment of periodontal disease. The laboratorial tests can be required as result of oral findings or when aspects of the treatment can potentially affect the patient's systemic health. Many times, the laboratorial exams are necessary to confirm a systemic disease or monitor its current situation.[24] All required exams, as well as its results must be carefully recorded in this item (Fig 4). There are spaces designated for recording the dates of these exams updates.

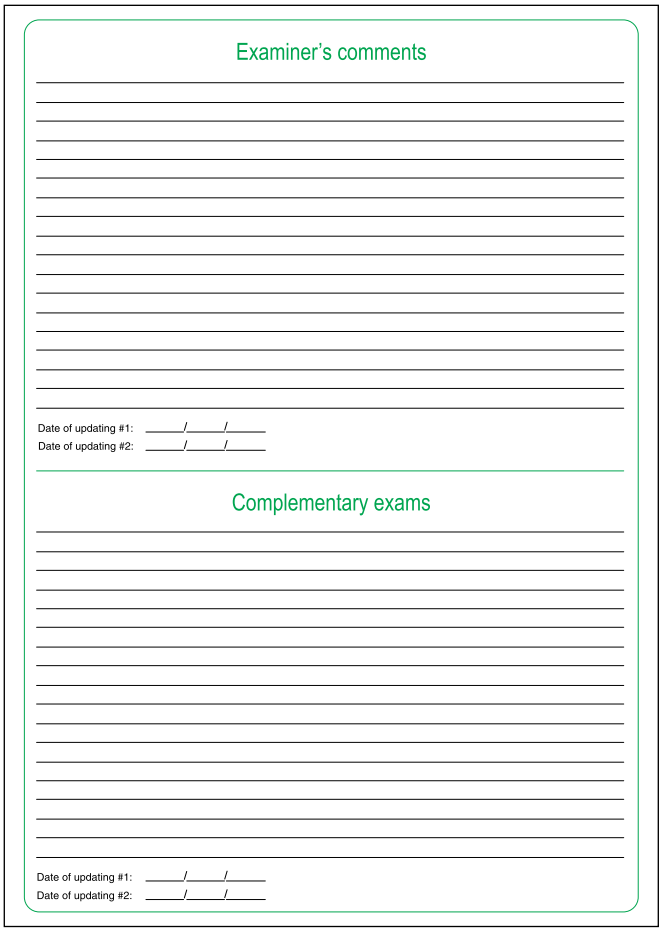



**Figure 4** - Examiner's comments and additional exams.

### *Periodontal chart*

The periodontal chart work as a guide for a direct exam and to record the patient's conditions. It is also used to evaluate the response to the treatment and for comparison to posterior visits.[25] The periodontal chart elaborated for this form (Fig 5) enable in a simple and quick way the recording of all periodontal alterations. Through the use of the signs described on the legend, the professional can mark the main clinical findings associated or predisposing to periodontal disease, such as: presence of diastema, open contact, food impaction, excess of restorations margins, degree of commitment of furcation lesions, degree of dental mobility, mesialization or distalization of the dental elements, presence of bleeding on probing, absence of papilla and presence of endodontic lesions. The boards above the dental diagram are designated to measurement of probing depth (PD), recession measure (Re) and amount of gingiva measure (Ge) on the initial appointment and after periodontal therapy. Although the absence of space related to insertion loss, fundamental item on periodontal analysis, it can be obtained through sum of

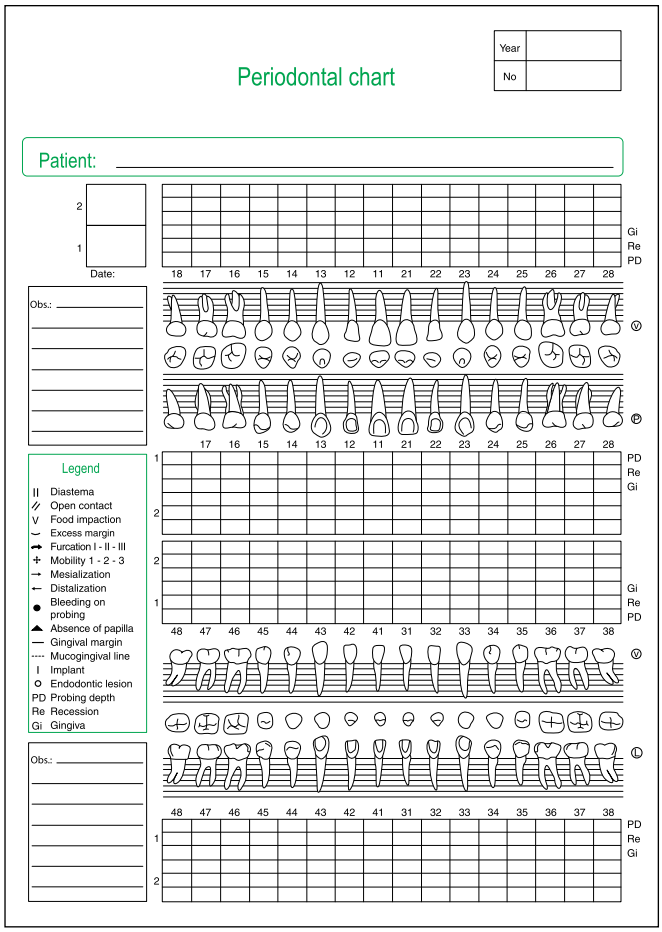



**Figure 5** - Periograma.

the recession (if existent) with the probing depth. On the boards denominated "Observations" located below and above the legend, it can be added other explanations about situations not enough graphically clarified. It is emphasized the importance of recording the date of the information note to allow evaluate the evolution of executed treatment on posterior measurements.

### *Plaque index (O'Leary)*

The plaque control record was developed to give the dentist, the sanitarian or the educator a simple method to record the presence of plaque on individual surfaces of the teeth (mesial, distal, buccal, lingual). The record allows the patient to visualize his own progress on plaque control and works as motivator.[26] The index used was the O'leary's due to greater facility to take notes and for the fact of being the one of greater acquaintance among academics.[27] In this space, below the records, it is found the formula for its attainment, facilitating its application in case of unawareness. There is space for six evaluations (Fig 6) that will be recorded on sessions determined by the professional.

### *Observations*

This item is reserved for additional data verified by the examiner concerning the patient's hygiene. Other orientations may be recorded such as brushing technique and frequency or type of suggested toothbrush, new orientations, collaborations and other relevant information (Fig 6).[28,29,30]

### *Diagnosis*

The correct periodontal diagnosis is an essential verification that will determine the efficiency of the treatment. In periodontal practice, the diagnosis is derivative from information obtained on the patient's medical and dental survey combined to findings of a deep oral exam. All signs and symptoms associated to the current condition must be considered before concluding the diagnosis. In some cases, additional information derivative from laboratory exams are useful on the global process of decision-making. Experienced clinicians prefer using the term differential diagnosis which is a list of possible diagnoses for that situation, organized from the most likely to the less likely. This provides the clinician other diagnostic options, in case the initial hypothesis is mistaken (Fig 7).[31]

### *Prognosis*

The prognosis is a preview of the probable course, duration and result of a disease based on general knowledge

of the pathogenesis and in presence of risk factors. It is established after the diagnosis is done and before the treatment plan is determined.[32] It will depend on several factors as disease severity and cooperation from the patient (Fig 7).[31]

### *Treatment plan*

After the diagnosis and prognosis have been established, the treatment plan is instituted, based on collected data from previous items associated to other dental and medical specialties. The treatment plan is the project for management of the case. On periodontal therapy, many times, the treatment plan includes the following decisions: teeth to be kept or extracted, techniques of pocket therapy – surgical or non-surgical that will be used, necessity of occlusal correction, endodontic or orthodontic therapy, necessity of temporary restoration, types of final restorations that will be necessary after periodontal therapy, teeth that will be pillars for the fixed prosthesis, esthetic considerations on periodontal therapy and therapy sequence.[33] The space designated to this item is vast so it can be included several options of possible treatment to that specific case and not only the ideal treatment.[29,34] Informed about all implications and after have done the choice for certain plan, the patient must date and sign on the proper lines (Fig 8).[35]

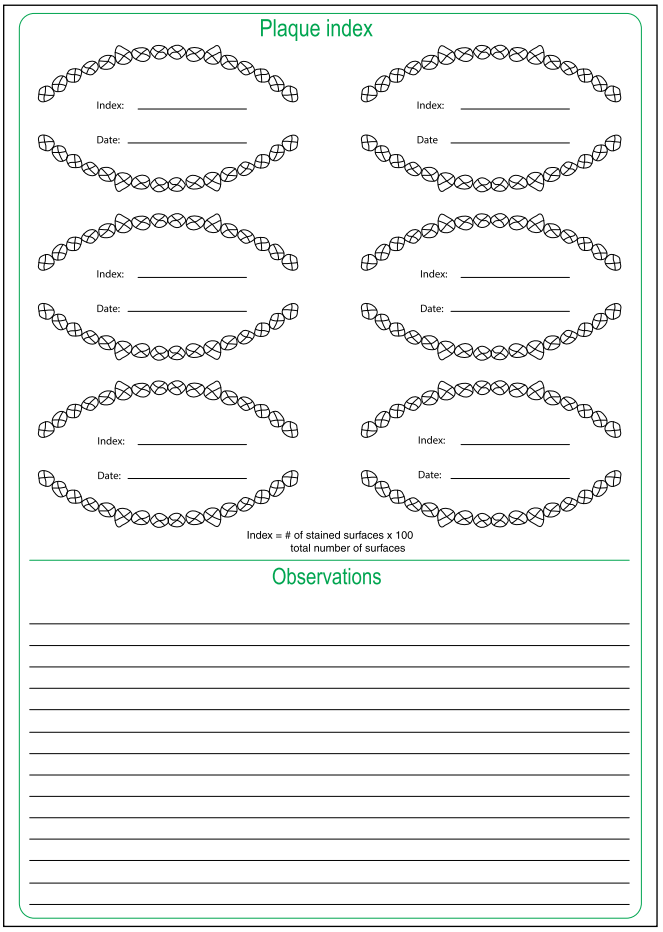



**Figure 6** - Plaque index.

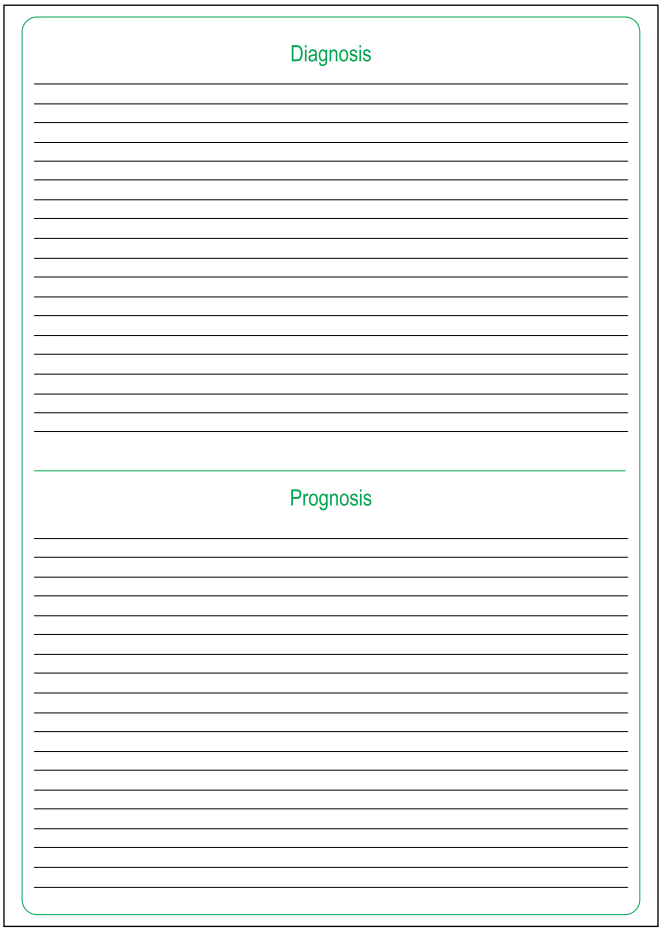



**Figure 7** - Diagnosis and prognosis.

### *Economic plan*

In case of private practice or institutions where the patients has to pay any fees, it is important to specify and record the cost of each procedure as well as the total cost of the treatment and the payment options. The patient's signature points his approval to the proposed conditions (Fig 8).

Procedures: It is indispensable on the clinical form the detailed description of performed procedures and used materials during the treatment. Besides, it also must be recorded all typed of occurrences such as: Intervention of other professionals, referral, modifications on the treatment plan and its reason, cases of delays, patient's absences and psychological behavior, hygiene condition and lack of collaboration.[36,37] These data have legal value, as a way to prevent lawsuit, for well elaborated clinical records will allow to explain the professional's situation and define is he executed the correct procedures and conduct (Fig 9).[38] It must be recorded the date and signature of the responsible professional. On the presented form, elaborated for academics purposes, there is space for signature of the student responsible for the procedure.


**Figure 8** - Treatment plan.

### *Envelope*

It gathers all data in an organized and convenient way (Fig 10). This envelope illustration has the traditional areas for filling in with the record number, patient's name, treatment initiation year and name of the students that performed the medical care (in case of educational institutions) and assembles a relevant differential on the superior left board: On it will be done, if necessary, an apparent mark aiming to quickly recognize any important situation that needs to be considered during treatment. Laterally there is space to mention the aggravations to be considered. This is extremely functional since, many times, these data, when recorded on the clinical form, can go unnoticed in subsequent visits, especially after a relevant period of time since the initial appointment.

### *Logo*

On figures 1, 5 and 10 it can be noticed the space reserved for logo of the institution or private practice.

## Results

The new model of clinical form was developed to offer to professionals and educational institutions a way of data storage that show in a succinct, yet complete, way all relevant and current information for an appropriate periodontal treatment plan (Fig 1-10).


**Figure 9** - Description of performed procedures.

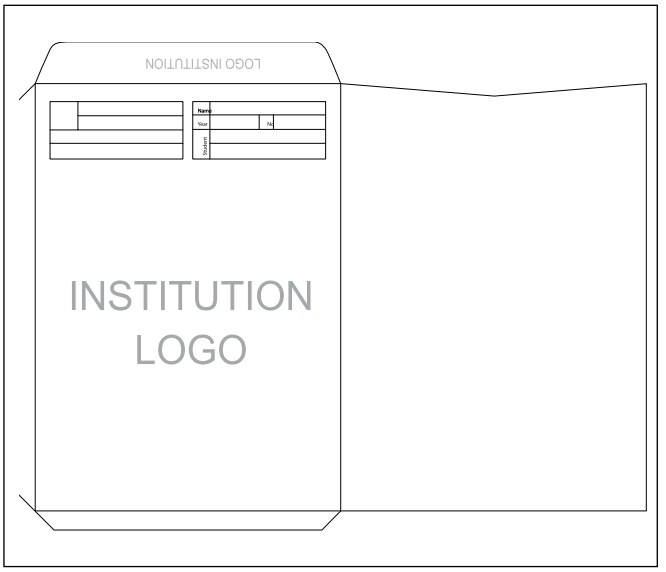



**Figure 10** - Envelope.

## Discussion

The definition of health, according to the World Health Organization, is not only based on the absence of disease, but on a complete state of physical, mental and social welfare.[39] It is fact that the oral health has serious implications on the human health, therefore a complete and adequate survey is necessary to obtain and record all relevant information for the beginning and progress of an efficient and safe treatment.[15] The periodontal disease, defined as an inflammation of the dental supporting tissues that leads to progressive destruction of bone tissue and periodontal ligament[40] is one of the chronic diseases of greater incidence on the world population today.[41] Even in developed countries it reaches over 85% of the adult population, affecting one or two teeth.[42,43] In Brazil, the percentage of individuals with periodontal disease is of 83% for adults between 35 and 44 years old, achieving 98.2% when considered the elderly between 65 and 74 years old.[44] Being a multifactorial disease, the methodologies used until early last decade did not have a classic standard to determine the illnesses presented by patients, making it difficult to store information due to divergences on the classification.[45-48] However, in 1999 an international meeting defined, in consensus, a new classification of periodontal diseases based mainly on the modulation between microorganism and host, being distributed in multiple categories of disease.[49] This new classification allowed clinicians and researchers to communicate more efficiently about the characteristic of the lesion acquired. This communication is through notes recorded on a periodontal clinic form that, the more

standardized[8] and easy to read, it facilitates the gathering of data allowing multicenter studies to be performed with a greater number of cases and increase the reliability of the presented results. An embracing and simple periodontal form model is of great utility specially for specialists on the beginning of their carriers when the concern with the adequate treatment plan and correct execution of techniques, associated to clinical inexperience may leave aspects prior to treatment such as medical survey and a judicious periodontal chart fill out on a second plan. A study performed in a university of São Paulo[50] verified that during graduation course most of the academics do not entirely fill out the forms for the difficulty to read and interpret or absence of adequate symbology. Another study analyzed the periodontal forms from 10 Brazilian universities and verified the lack of adequacy to didactic and clinical needs of the analyzed forms. As an example it can be mentioned that from all assessed forms, only four presented the item "Medical history", and from these, only one presented it appropriately.[8] The presented form was developed to facilitate its reading and comprehension: an apparent mark on the envelope's superior left board alerts for a supposed main problem (Fig 10). Then, there are items of full identification and medical and dental history with simple terminology (Figs 1, 2, 3). It presents, on the clinical part, a periodontal chart where the dental structures are reported with dental format and not symbols, facilitating the reading and with markings positioned right above the referred teeth (Fig 5). Besides, it offers enough space for observations, diagnosis, prognosis, detailed treatment and economic plans, where the patient's signature is required making it mutual the responsibility for the execution and honoraria of the professional when necessary (Figs 7 and 8). It estimates a space for examiner's comments and complementary exams (Fig 4) that will be recorded and become particularly important in case of switching professionals or demand of other specialties. This form comprises all parameters for the recording of data and its formulation estimate certain versatility that can be adapted to academic purposes or private practice.

## Conclusion

In Periodontics, there is a great difficulty to establish a periodontal form model, due to variety of collected data that must be converted systematically in a written and comprehensive treatment plan. When it is assessed the didactic matter, this difficulty is emphasized since it is necessary a form of easy comprehension, simple and that comprises and fulfill the present requirements needed to periodontal exam. Through the analysis of several periodontal forms and study of legal requirements, it was possible to elaborate a complete periodontal form that allows the recording of procedures in a safe way that comprises all clinical data and findings that guide the periodontal treatment.

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