**PAEDIATRIC & PREVENTIVE DENTISTRY**

**SATHYABAMA DENTAL COLLEGE & HOSPITAL**

**Post Graduation**

**Frankel’s Rating Scale:**

**Date :**

**Reg. No.:**

Name: Nick Name:

D.O.B: Age/sex: Place of Birth:

Address:

Telephone No:

Parent's Occupation:

Ethnic Origin: Religion:

Child's Pediatrician: Referred By:

Informer:

**Chief Complaint:**

**History of Presenting illness:**

**Parental History**

* Were your / your spouse’s teeth grey, yellow or brownish in colour?
* Any other problem with your / your spouse’s teeth?
* Are you / your spouse frightened of dental treatment?

**Prenatal History**

* Mother’s condition during pregnancy :
* Were you on any drug therapy?
* If yes, what drug & for how long?
* Are you / your spouse RH negative?

**Natal History**

* Delivery : Full Term / Premature
* Type : Normal / Forceps / Caesarean

**Past Medical History**

**Past Dental history**

**Post Natal History**

* Feeding : Breast / Bottle / Combination
* Duration & Frequency :
* Type of nipple used for bottle-feeding :
* Milestones of development : Normal / Delayed
* Childhood Diseases :
* Was your child Immunized :
* Habits:
* Does he/ she have frequent minor accidents or injuries? Yes / No
* Does he/ she have any mental physical

disability or any other disease? :Yes / No

* Is he/ she allergic to any food or Drugs? Specify :
* Does he/ she have difficulty in making friends? : Yes / No
* Does he/ she fail to get along with other Children? Yes / No
* Does he/ she play Indoor or Outdoors :
* Does he/ she have sibling?

If yes, what is their age?

* Does he/ she have difficulty in keeping up with

School work : Yes / No

* Has he/ she visited a dentist before : Yes / No
* Does he/ she fear the dentist? If yes, why?

**DIET CHART**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Time | Type of Food | Amount of sugar added | Type of sugar |
|  |  |  |  |  |

Number of Sugar Exposures:

Cariogenic / Non-Cariogenic diet :

**CLINICAL EXAMINATION**

**GENERAL EXAMINATION**

Build: Height: Weight:

Gait: Posture: Body type:

Shape of head:

**EXTRA ORAL EXAMINATION**

Facial Form :

Facial Profile :

Facial Symmetry :

Facial Divergence:

Lip posture & Tonicity:

TMJ Examination :

Lymph node Examination :

**INTRA ORAL EXAMINATION**

|  |  |  |
| --- | --- | --- |
| **Soft Tissue** | **Normal** | **Pathology, If any** |
| Skin / lips  Mucosa(Labial/Buccal)  Palate  Floor of mouth  Tongue  Glands  Gingiva  Tonsils  Frenal Attachment |  |  |

**Teeth present:**

**Clinical Findings:**

**Molar Relationship** Right Left

Primary :

Permanent :

Primate space :

Eruption Sequence :

**Canine relationship** :

**Incisor relationship**

Overjet :

Overbite :

Openbite :

Cross bite :

Midline: Normal / deviated

**Arch length:**

Maxilla : Adequate / Inadequate

Mandible : Adequate / Inadequate

Analysis recommended : Yes / No

**Dental Caries Score**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Tooth No | | Visual | | | | | Radiograph | Other findings |
| O | B | M | L | D |
| 18 |  |  |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  |  |  |
| 15 | 55 |  |  |  |  |  |  |  |
| 14 | 54 |  |  |  |  |  |  |  |
| 13 | 53 |  |  |  |  |  |  |  |
| 12 | 52 |  |  |  |  |  |  |  |
| 11 | 51 |  |  |  |  |  |  |  |
| 21 | 61 |  |  |  |  |  |  |  |
| 22 | 62 |  |  |  |  |  |  |  |
| 23 | 63 |  |  |  |  |  |  |  |
| 24 | 64 |  |  |  |  |  |  |  |
| 25 | 65 |  |  |  |  |  |  |  |
| 26 |  |  |  |  |  |  |  |  |
| 27 |  |  |  |  |  |  |  |  |
| 28 |  |  |  |  |  |  |  |  |
| 38 |  |  |  |  |  |  |  |  |
| 37 |  |  |  |  |  |  |  |  |
| 36 |  |  |  |  |  |  |  |  |
| 35 | 75 |  |  |  |  |  |  |  |
| 34 | 74 |  |  |  |  |  |  |  |
| 33 | 73 |  |  |  |  |  |  |  |
| 32 | 72 |  |  |  |  |  |  |  |
| 31 | 71 |  |  |  |  |  |  |  |
| 41 | 81 |  |  |  |  |  |  |  |
| 42 | 82 |  |  |  |  |  |  |  |
| 43 | 83 |  |  |  |  |  |  |  |
| 44 | 84 |  |  |  |  |  |  |  |
| 45 | 85 |  |  |  |  |  |  |  |
| 46 |  |  |  |  |  |  |  |  |
| 47 |  |  |  |  |  |  |  |  |
| 48 |  |  |  |  |  |  |  |  |

**Radiographic investigations:**

**Diagnosis:**

**Treatment plan:**

**Mode of Management** : Chair-side / Inhalation Sedation / General Anaesthesia

**Treatment Done**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Treatment** | **Date of next appointment** | **Signature of the Staff** |
|  |  |  |  |

**Complete Records**

1. Study models & Analysis:
2. X-rays:
3. Cephalogram:
4. Photographs:

STUDENT'S NAME: SUPERVISOR'S SIGNATURE