



FOLLOW-UP CHECKLIST FOR COMPREHENSIVE CARE PATIENTS

1. Patient Information

- **Patient Name:** _____
- **Age:** _____
- **Gender:** _____
- **Date of Follow-up:** _____

2. DIAGNOSTIC CHART

A. Chief Complaint

B. Medical History

- Systemic conditions:

- Medications:

- Allergies:

- Habits (Smoking, bruxism, mouth breathing, etc.):

C. Dental History

- Previous dental treatments:

 - Past complications:

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3. EXTRA-ORAL EXAMINATION

A. General Assessment

- Facial symmetry: ☐ Normal ☐ Asymmetric
- TMJ tenderness/clicking: ☐ None ☐ Right ☐ Left
- Lymph nodes: ☐ Normal ☐ Tender ☐ Enlarged
- Masticatory muscle tenderness: ☐ Yes ☐ No
- Maximum mouth opening: _____ mm

B. Perioral Soft Tissues

- Lips: ☐ Normal ☐ Cracks ☐ Lesions
- Skin: ☐ Normal ☐ Pigmentation ☐ Lesions

4. INTRA-ORAL EXAMINATION

A. Soft Tissue Assessment

- Oral mucosa: ☐ Normal ☐ Ulcer ☐ White/red lesions
- Gingiva: ☐ Healthy ☐ Inflamed ☐ Recession
- Tongue: ☐ Normal ☐ Coated ☐ Lesions
- Floor of mouth: ☐ Normal ☐ Swelling ☐ Lesion
- Saliva: ☐ Normal ☐ Reduced (dry) ☐ Excessive

B. Periodontal Examination

- Gingival Index (GI): _____
- Furcation involvement:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8



5. DENTAL CHARTING

1. General Tooth Condition

- Overall hygiene: ☐ Good ☐ Fair ☐ Poor
- Staining: ☐ None ☐ Mild ☐ Moderate ☐ Severe
- Calculus: ☐ None ☐ Supragingival ☐ Subgingival

2. Tooth-by-Tooth Checklist

- **C** = Caries
- **F** = Filling
- **R** = Root canal Failure
- **M** = Missing
- **Cr** = Crown Failure
- **Fx** = Fracture
- **Mo** = Mobility
- **P** = Pain/sensitivity

1. Caries

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

2. Filling

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

3. Root Canal Failure

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

4. Missing

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

5. Crown Failure

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8



6. Fracture

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

7. Mobility

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

8. Pain/ Sensitivity

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

6. PROSTHODONTIC ASSESSMENT (If applicable)

- Denture fit: ☐ Good ☐ Needs relining ☐ Needs replacement
- Patient satisfaction: ☐ Satisfied ☐ Unsatisfied

7. RADIOGRAPHIC FINDINGS

- Periapical status:

- Horizontal bone loss:

- Vertical bone loss:

- Pathology detected:

8. FOLLOW-UP OUTCOME

- Success of previous treatment: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Patient compliance: ☐ Good ☐ Fair ☐ Poor
- Maintenance required:
