

## Head and Neck Clinic – Dental Assessment Form

### OUTPATIENT RECORD Department of Oral Health

DATE: ..... / ..... / .....

Diagnosis:

Previous/Current Management:

Relevant medical history:

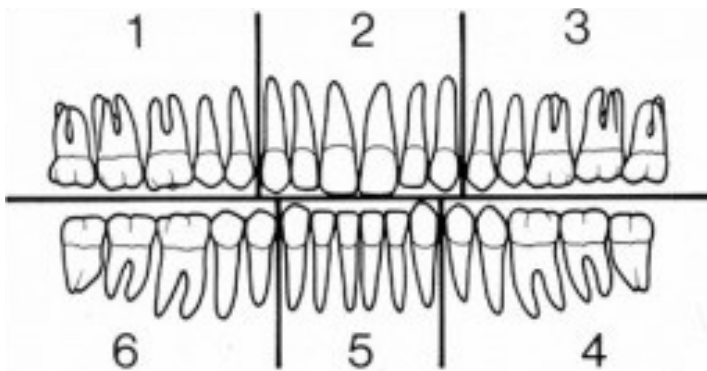
#### Relevant drug history

Drug history:

Allergies:

Radiotherapy:                      Curative                      Palliative

Chemotherapy:                      Yes                      No



Radiation fields:

(High/Med/Low dose)

**Clinician Name:**

**Designation:**

**Clinician Signature:**