Head and Neck Clinic – Dental Assessment Form

OUTPATIENT RECORD
Department of Oral Health

DATE: …… / …… / ……

Diagnosis:

Previous/Current Management:

Relevant medical history:

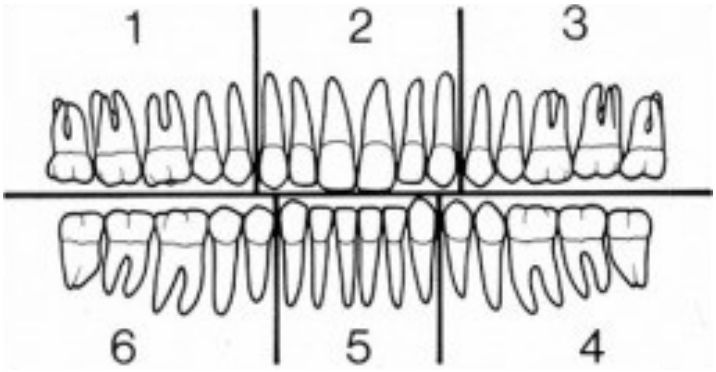
<u>Relevant drug history</u>

Drug history:

Allergies:

Radiotherapy: **Curative** **Palliative**

Chemotherapy: **Yes** **No**



Radiation fields:

(High/Med/Low dose)

Clinician Name: **Designation:**

Clinician Signature: