DATE, CITY

UNIVERSAL DENTAL EXAMINATION IN SPORTS

EXAMINING DENTIST

______________________ ______________________

1. GENERAL INFORMATION (filled by athlete)

FIRST NAME__________________ LAST NAME__________________ SEX M/F BIRTH DATE ___/___/___ WEIGHT_____ HEIGHT_____
ADDRESS__________________________ (street) _____(number) ______________(city) __________(PC) ____________________(country)
PHONE NUMBER___________________ email_____________________________ SPORT____________________YEARS OF EXPERIENCE_____
CURRENT TEAM_____________________COUNTRY_____________ DOCTOR______________________ DENTIST_________________________

2. DENTAL HISTORY (filled by athlete)

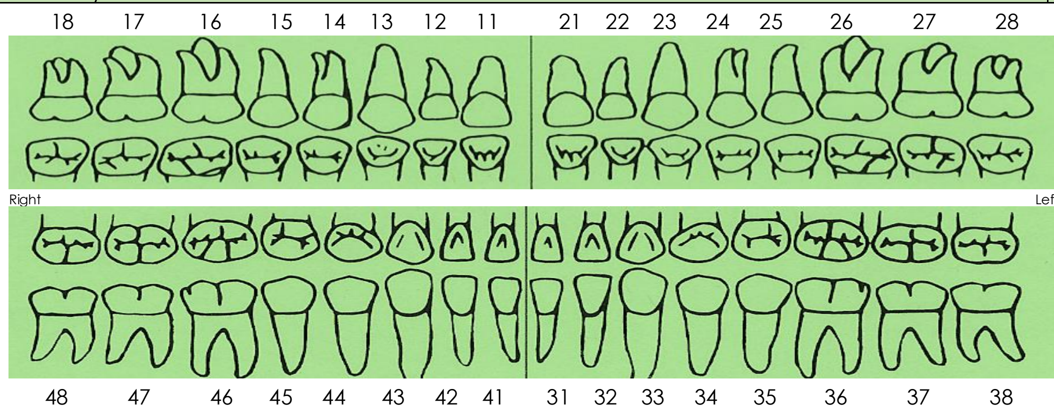
Last visit to Dentist: 0-6 months___ 6-12 months___ >1 year___ **Dental checkups frequency**: 1/year___ 2 or more/year___ <1 year___
Past dental treatments: fillings___ root canal___ extraction___ prosthetics___ surgery___ implant___ periodontal___
dentures___ orthodontic___ year completed___
Allergies/intolerance to medications: yes / no medication:___________
Have you ever experienced: jaw injury Yes / no specify: ___________________________________
Diet: sodas, lollipops, sports drinks (number per day)____, Smoking/chew tobacco (times per day)____ Alcohol drinks per day____
MOUTHGUARDS: yes / no type: custom made___ prefabricated___ boil & bite___ occlusal splint: yes / no
Do you wear one: always_____ sometimes_____ never_____

How often you had the following problem during the last month?	Very often	Fairly often	Occasionally	Hardly ever	Never
Have you had difficulty chewing any foods because of problems with your teeth, mouth, dentures, or jaws?					
Have you had painful aching in your mouth?					
Have you felt uncomfortable about the appearance of your teeth, mouth, dentures, or jaws?					
Have you felt that there has been less flavor in your food because of problems with your teeth, mouth, dentures, or jaws?					
Have you had difficulty doing your usual jobs because of problems with your teeth, mouth, dentures, or jaws?					

3. INITIAL DENTAL EXAMINATION (filled by dentist)

																		OVERALL SCORE
Negative on Temperature																		
Positive on Percussion																		
Positive on Pressure																		
Demineralization																		
Erosion																		
Abrasion																		
Attrition																		
ICDAS (0 to 6)																		
Eden-Baysal Dental Trauma Index																		
DMFT (Decayed-Missing-Filled Teeth Index)																		

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28



48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

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DMFT (Decayed-Missing-Filled Teeth Index)																		
																		OVERALL SCORE

Chart symbols to be filled on each tooth in presence of: filled teeth (•), missing teeth (x), devitalized teeth (I), infectious teeth (abscess O), crowned teeth (prosthetics U), cracked teeth (/)

4. PERIODONTAL SCREENING (filled by dentist)

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	OVERALL SCORE
BOP (yes/no)																	
PI Quigley & Hein Plaque Index score 0 to 3																	
GI Loe & Silness Ginvival Index score from 0 to 3																	
Recession																	
Mobility																	
CAL (mm)																	
PPD (mm) B																	
PPD (mm) L																	

	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	OVERALL SCORE
PPD (mm) B																	
PPD (mm) L																	
CAL (mm)																	
Mobility																	
Recession																	
GI																	
PI																	
BOP (yes/no)																	

Oral Cancer Screen	Normal	Abnormal	Notes
Palate			
Lips			
Tongue			
Throat/neck			
Cheeks			

Floor of mouth	Normal	Abnormal	Notes	
Fraenum				
Saliva	pH:			Flow: ml/min
Diagnosis	P	G	Periodontitis (P) / Gingivitis (G)	

5. MUSCULOSKELETAL SCREENING (filled by dentist)

Reported pain in the face and/or temples: yes / no, **TMJ noise:** yes / no, **Mandibular movement limitations:** yes / no,
Pain on muscle palpation: yes / no, **Pain on TMJ palpation:** yes / no

Functional analysis_____ Asymmetry _____ Opening/Closing of the mouth _____ Deviation (mm) _____

Limited mouvement	mm	Deviation	
Overbite		R	L
Max mouth opening		R	L
Right laterotrusion		R	L
Left laterotrusion		R	L
Protrusion		R	L
Retrusion		R	L
Palpation/TMJ			
Pain lateral		R	L
Pain posterior		R	L
Pain intra-meatal		R	L

Locking	R	L
Clicking	R	L
Crepitus	R	L
Compression	R	L
Endfeel	R	L
Deviation		
20		20
R		L
	20	
	40	
	60	

Muscles	Pain		Tension	
Masseter superficial	R	L	R	L
Masseter deep	R	L	R	L
Temporalis anterior	R	L	R	L
Pterygoioid lateral	R	L	R	L
Trapezius muscles	R	L	R	L
Digastric	R	L	R	L
Sternocleidomastoid	R	L	R	L
Counter-resistance opening	R	L	R	L
Counter-resistance anterior	R	L	R	L
Counter-resistance lateral	R	L	R	L

RADIOGRAPHIC EXAM TAKEN (attached as annexed): panoramic___ bitewing___ other___ **OCCLUSAL RECORD TAKEN:** yes / no
ORTHODONTIC EXAM: Angle's Class:______ **Headaches present:** yes / no - morning / nocturnal / during exercise

6. PARALYMPIC ATHLETES (filled by dentist)

Disability: Physical___ Sensorial___ Intellectual___ First appearance: _________ (date)
Causes: Genetic___ Congenital___ Trauma___ Disease___ Degenerative___ **Activity/sport before disability:** ________________

		Superior			Inferior		
Appendage function	Right	Normal	Reduced	Absent	Normal	Reduced	Absent
	Left	Normal	Reduced	Absent	Normal	Reduced	Absent

Disease: ______________________________ Medications:___________________________ Rehabilitation: yes / no

7. SPORTS DENTAL SCREENING PROTOCOL OUTCOME

ATHLETE IS IN GROUP: GREEN YELLOW RED

(according to the FDI guidelines: Green/no pathological and/or functional findings, Yellow/presence of at least one pathological or functional finding, Red/multiple severe pathological and/or functional findings)

ELIGIBILITY TO PRACTICE SPORTS: YES / NO