

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 _____

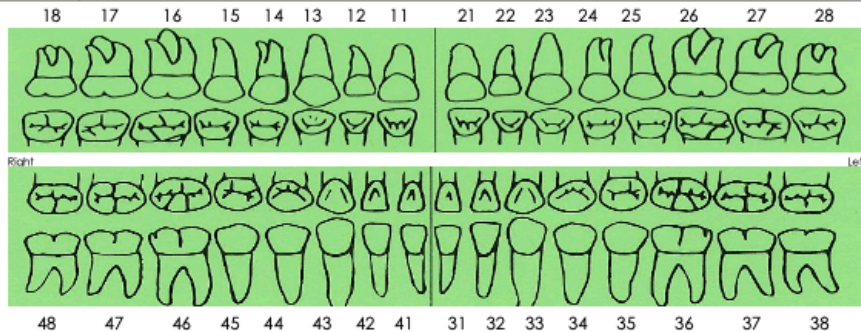
MOUTHGUARDS: yes / no type: custom made _____ prefabricated _____ boil & bite _____ occlusal splint: yes / no

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)

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



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

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 (/)

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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																	
GI																	
Recession																	
Mobility																	
CAL (mm)																	
PPD (mm)																	
PPD (mm)																	
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 movement	mm	Deviation	Locking	R	L	Muscles	Pain	Tension
Overbite		R L	Clicking	R	L	Masseter superficial	R L	R L
Max mouth opening		R L	Crepitus	R	L	Masseter deep	R L	R L
Right laterotrusion		R L	Compression	R	L	Temporalis anterior	R L	R L
Left laterotrusion		R L	Endfeel	R	L	Pterygoid lateral	R L	R L
Protrusion		R L	Deviation			Trapezius muscles	R L	R L
Retrusion		R L	20	20		Digastric	R L	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:** _____

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

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

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