

CASE HISTORY & CLINICAL EXAMINATION

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HISTORY

- History is defined as a planned professional conversation followed by accurate recording of facts.
- History plays a most important part in the diagnosis.
- A carefully taken history should give a clear indication of the nature of the problem and may in itself provide the diagnosis.



OBJECTIVES OF OBTAINING A HISTORY

1. To establish a positive professional relationship.
2. To provide the dentist with information concerning the patients past and present medical, dental and personal history.
3. To provide with information that may be important for making a diagnosis.
4. To provide information that aids the dentist in making decisions concerning treatment.

PRINCIPLES OF HISTORY TAKING

1. Put the patient at ease.
2. Choose an appropriate setting.
3. Start by eliciting the present complaint.
4. Encourage the patient to give an uninterrupted history.
5. Use selective questions to clarify the presenting history further.
6. Use further questions of diagnostic relevance.
7. Ask cardinal questions while reviewing the systems.
8. Use language the patient understands.
9. Avoid suggesting symptoms or answers to the patient.
10. Write notes while the patient is talking.




DIAGNOSIS AND DIAGNOSTIC SEQUENCE

Diagnosis is the identification of disease or abnormality by correlation of information obtained by the use of scientific knowledge & methods.

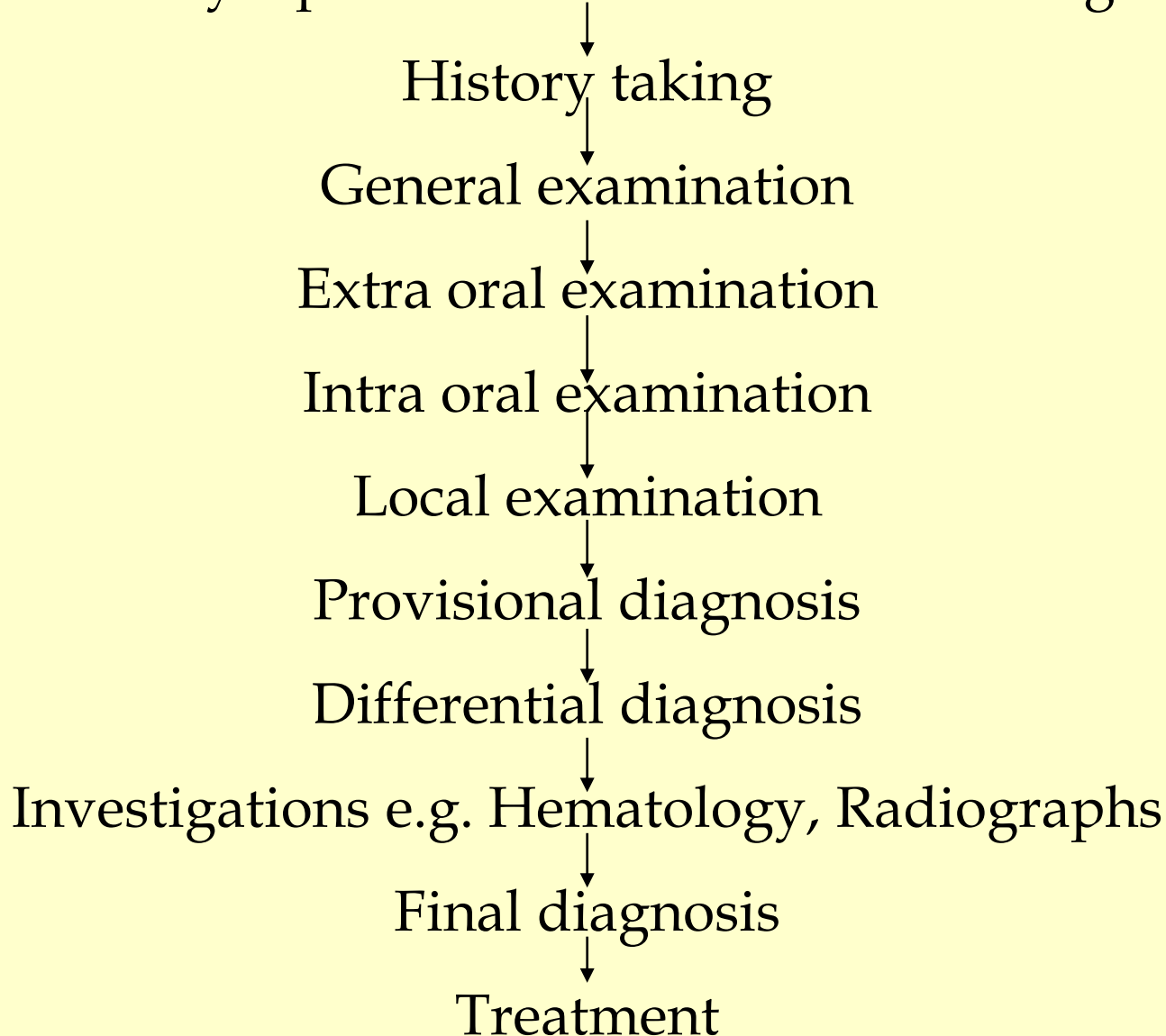
In simple words, diagnosis would mean recognizing the disease and naming it.

Diagnostic sequence is a series of steps that the clinicians take to arrive at a diagnosis.



THE DIAGNOSTIC SEQUENCE

Discovery either by a patient or a doctor of something abnormal

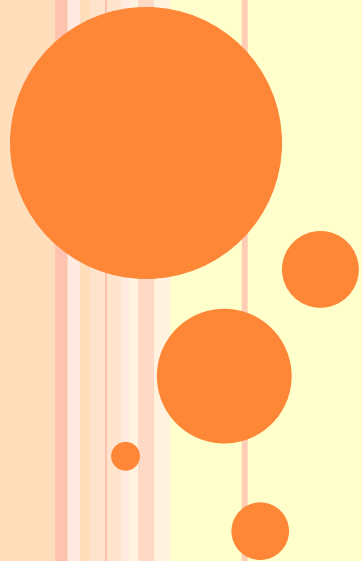


METHODS OF OBTAINING THE PATIENT'S HISTORY

- Three methods
 1. Interview
 2. Health questionnaire
 3. Combined



HISTORY PROFORMA



HISTORY TAKING



PERSONAL DATA

- Name :
- Age :
- Sex :
- Occupation :
- Race & Religion :
- Marital status :
- Residence :



CHIEF COMPLAINT

- The chief complaint is the primary reason why the patient seeks a dentist's opinion. It should be recorded in the patient's own words and should be in a chronological order.
- If few complaints start simultaneously then list them in the order of severity.
- Other details required are origin, duration, progress, aggravating factors, relieving factors and Past treatment done related to chief complaint.



HISTORY OF PRESENT ILLNESS

- Origin : Records how the problem started. e.g. Whether the onset was sudden or gradual.
- Duration : Meaning how many days, weeks or months the problem has existed.
- Progress : Denotes whether the problem is static, getting worse or getting better.



Associated complaints:

- Pain
- Swelling
- Ulceration
- Burning sensation
- Bleeding gums, mobile teeth or halitosis

Past Dental Treatments:

- Type of treatment
- Any complaints regarding to it



MEDICAL HISTORY

a.) Major illness

- Vitamin Deficiency
- Blood Dyscrasias
- Endocrine Disturbances
- Dermatological Diseases
- Bone Diseases
- Sexually Transmitted Diseases
- Cardiovascular Diseases
- Asthma
- Genetic Diseases
- Allergic Condition
- Neural Diseases

b.) Medication

- Drug history
- Dependency
- Allergy

c.) History of Hospitalization



IMPLICATIONS FOR DENTAL TREATMENT RELATING TO HEALTH STATUS.

- **Level 1** : Patient can receive routine dental treatment, no modification necessary.
- **Level 2** : Routine dental treatment may require modification such as medical consultation, shortened appointment length, use of sedatives or antibiotic premedication
- **Level 3** : Routine dental treatment is indicated, but treatment modifications are almost certainly indicated and may be more complex.
- **Level 4** : Only emergency dental treatment is indicated. Whenever possible, dental treatment should be postponed until the patient's medical condition has improved to at least a level 3 classification. Emergency treatment should be performed in a hospital dentistry setting.

PERSONAL HISTORY

- Tobacco Habit –Method of usage
 - Type of usage
 - Frequency of usage
 - Duration of usage
- Alcohol Habit
- Other Oral Destructive Habits
- Diet – type, quantity, frequency
- Bowel and Bladder Habits
- Appetite
- Sleep habits



- Oral Hygiene – Method – Datun/Finger/Brush
measures Dentifrice/Paste/Powder

- Frequency

- Brushing Technique

- Tongue Cleaning

- Flossing

- Mouthwash

- Family History



CLINICAL EXAMINATION



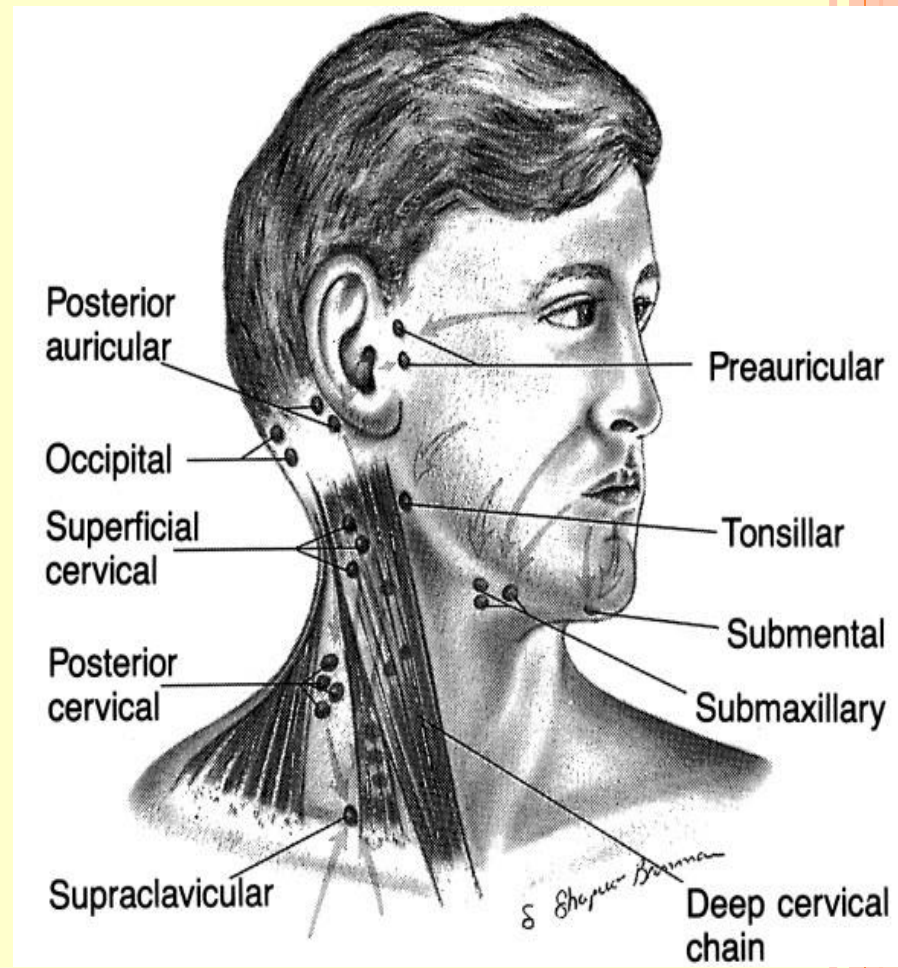
GENERAL EXAMINATION

- Consciousness, Co-operation, Orientation
- Gait, Built, Posture
- Vital signs
 - A.) Temperature
 - B.) Pulse
 - C.) Respiration
 - D.) Blood pressure



EXTRA ORAL EXAMINATION

- Facial form and symmetry
- Temporomandibular joint
 - a.) Inspection – Defects – Swelling/Depression
Movements
 - b.) Palpation – Tenderness
Crepitus
Movements
 - c.) Auscultation
- Lymphnodes – Involvement
 - Enlarged
 - Tenderness
 - Consistency
 - Fixity



OTHERS

- Head
- Nose, Eyes & Ears
- Neck & Throat
- Extremities & Digits
- Chest & Abdomen
- Skin
- Hair & Nails



INTRA ORAL EXAMINATION

A) Hard Tissue Examination

1.) *Teeth*

- Number
- Size
- Shape
- Colour
- Consistency
- Attrition, Abrasion, Erosion, Abfraction
- Any restorations, crown, bridge
- Mobility, Pain on percussion or Root pieces

2.) *Occlusion*

- Classification (Angle`s)
- Deranged
- Any occlusal interferences



B.) SOFT TISSUE EXAMINATION :

- Gingiva : Size/ Colour/ Contour/ Consistency/ Texture/ Surface/ Position/ Bleeding
- Lips and labial mucosa
- Buccal mucosa
- Alveolar mucosa and vestibular region
- Palatal mucosa




- Tongue:
Size/Shape/Colour/
Movements & Muscle
tone/Dorsum/
Lateral & Ventral surface
- Floor of the mouth
- Salivary glands & its
orifices: Salivary flow/
Viscosity/Discharge



LOCAL EXAMINATION



METHODS OF EXAMINATION

- Inspection: Visual examination of the body using eyes and a lighted instrument if needed, the sense of smell may also be used.
 - Palpation: The act of feeling with the hand; the application of the fingers with light pressure to the surface of the body for the purpose of determining the condition of the parts beneath in physical diagnosis.
 - Percussion: Striking a part of the body with short, sharp blows of the fingers in order to determine the size, position, and density of the underlying parts by sound obtained.
 - Auscultation : listening for sounds within the body; may be performed with the unaided ear or with a stethoscope.
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SWELLING OR LUMP

a.) Inspection

- Site
- Number
- Colour
- Shape & Size
- Surface
- Edges
- Pulsation
- Movements with respiration
- Movements with deglutition
- Movement with protrusion of tongue
- Impulse on coughing
- Overlying Skin or Mucosa
- Pressure effect
- Discharge

b.) Palpation

- Number
- Size, Shape & Extent
- Edges
- Consistency
- Fluctuation
- Translucency
- Impulse on coughing
- Reducibility
- Compressibility
- Pulsatility
- Fixity to overlying skin
- Relation to surrounding structures
- Temperature
- Tenderness
- Discharge

c.) Aspiration



GROWTH

a.) Inspection

- Site
- Shape
- Number
- Colour
- Surface
- Pedunculated/Sessile
- Pain
- Overlying Skin or Mucosa
- Surrounding area

b.) Palpation

- Site
- Shape
- Number
- Colour
- Surface
- Consistency
- Tenderness
- Surrounding area
- Fixity



ULCER

a.) Inspection

- Location
- Size
- Shape
- Number
- Edges
- Floor
- Discharge
- Surrounding area

b.) Palpation

- Tenderness
- Edge
- Base
- Depth
- Bleeding
- Relation to deeper structures
- Surrounding areas



- **Case Analysis** is sum of all the positive points of history and examination to analyze them.
- **Provisional Diagnosis** is the diagnosis arrived at from the findings of history & clinical examination.
- **Differential Diagnosis** is the process of identifying a condition by differentiating all pathologic processes which may produce similar lesions.



INVESTIGATIONS



1.) Routine

- CBC – RBC Count
WBC – TC, DC
Platelet Count
Hb
ESR
BT
CT
- Blood glucose
- Urine glucose

2.) Specific

- Surgical - Biopsy – Excisional
Incisional
Punch
Wedge
- Cytosmear
- Fine Needle Aspiration Cytology (FNAC)



- Clinical test
 - Glucose tolerance
 - Serum tests
 - Serological test for syphilis
 - SGPT
 - Billirubin

3.) Sialochemistry

4.) Urine Examination

5.) Stool Examination

6.) Pulp Vitality

7.) Radiographic Investigations

- Intra Oral

- IOPA
- Bite wing
- Occlusal
- RVG



- **Extra Oral**
 - PNS
 - AP Skull
 - Lateral Oblique
 - Trans cranial, Trans orbital, Trans pharyngeal
 - PA Mandible
 - Reverse Towne
 - Submentovertex
- **Panaromic**
- **Specialized Radiographic & Imaging Techniques**
 - CBCT
 - CT Scan
 - MRI
 - Ultrasonography
 - Doppler`s Test
 - Angiography
- **Sialography**
- **Arthrography**
- **Any other investigations**



○ Radiographic Interpretation

- Some radiographs are advised as routine investigations so in case of that radiographic interpretation is included in case analysis.
- **Final Diagnosis** is the identification of disease or abnormality by correlation of information obtained by the use of scientific knowledge & methods



TREATMENT PLAN

- Symptomatic/ Definitive
- Procedure, Prognosis, Complication, Side-effects, Time and Expense should be explained
- Medical risk assessment
- Removal of etiology



**THANK
YOU**

