Registry of Oral potentially malignant disorders

B form

1. Patient personal details

Country:

City:

Hospital:

Doctor:

Insurance number:……..

Name:……

Date:……..

Visit (number): ……..

2. Changes in complaints:

Pain: no symptom / no significant change / symptom is over / improvement / worsening

Burning sensation: no symptom / no significant change / symptom is over / improvement / worsening

Discomfort: no symptom / no significant change / symptom is over / improvement / worsening

Itching sensation: no symptom / no significant change / symptom is over / improvement / worsening

Dry mouth (xerostomia): no symptom / no significant change / symptom is over / improvement / worsening

Bad breath (halitosis): no symptom / no significant change / symptom is over / improvement / worsening

Bad taste sensation: no symptom / no significant change / symptom is over / improvement / worsening

Bleeding while brushing the teeth: no symptom / no significant change / symptom is over / improvement / worsening

Difficulty swallowing: no symptom / no significant change / symptom is over / improvement / worsening

Other new symptom: Yes/no
if yes, specify:…….
symptom severity: mild / moderate / severe

3. Details in medical history / Risk factors

Habits

Have your smoking habits changed since the last visit? yes / no
if no: still non smoker/ still smoking same amount and type(s)
if yes: complete cessation
reduced amount same type(s) type:…… filtered/unfiltered/N.a
……amount/day
increased amount same type(s) type:…… filtered/unfiltered/N.a
……amount/day
changed type or use different type(s) simultaneously type: ……
filtered/unfiltered/N.a, ……amount/day

Have your habits related to smokless tabacco usage change? yes/no
if no: still non consumer/ still consume same amount and type(s)
if yes: complete cessation
reduced amount same type(s) type:……..
;……occasion/day
increased amount same type(s) type:…….. ;
…… occasion/day
changed type or use different type(s) simultaneously type: ……..;
…… occasion/day

Have your habit related to alcohol consumption change?: yes / no
if no: still non consumer/ still consume same amount
if yes: complete cessation
reduced amount …….g/day
increased amount …… g/day

Guide for estimation of the amount:
1 dl beer (4.5 vol. %) = ~3.5 g alcohol

1 dl wine (12.5 vol. %) = ~10 g alcohol
1 dl hard drink (50 vol. %) = ~40 g alcohol

Have you changed your habits related to coffein consumption? yes/no
if no: still non consumer/ still consume same amount and type(s)
if yes: complete cessation
reduced amount same type(s) type:……..
;……dose/day
increased amount same type(s) type:…….. ;
…… dose /day
changed type or use different type(s) simultaneously type: ……..;
…… dose/day

Drug abuse: yes/no *Prescribed medication should not be included here.*
if yes: previously recorded? yes / no
if no: type of drug:…….
amount:…….
for how many years:……

4. Diseases and medications:

Changes in diseases since previous medical history was taken? yes/no
Changes in medication since previous medical history was taken? yes/no

Cardiovascular diseases

Hypertension: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Arrhythmia: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Atherosclerosis: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Other cardivascular disease: yes / no
if yes:
specify:……
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Drugs taken for cardiovascular diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Chronic infectious diseases

HBV: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

HCV: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

HIVs: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

HPV: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Other chronic infectious disease: yes/no
if yes:
specify:……
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Drugs taken for infectious diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Gastrointestinal diseases

GERD: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Crohn disease: yes/no

if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Colitis ulcerosa: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

IBD: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Gluten intolerance/Coeliac disease: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Lactose intolerance: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Other gastrointestinal disease: yes/no
if yes:
specify:……
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Drugs taken for GIT diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

<u>Endocrinopathy</u>

Diabetes mellitus: yes/no
if yes:
previously recorded diagnosis: yes / no,
if no: Type:I / II / IIIc / MODY

Date of diagnosis (year):……,

Thyroid disease: yes/no
If Yes:
previously recorded diagnosis: yes / no,
if no: hyperthyroidism/hypothyroidism/other:……
Date of diagnosis (date: year)…….

Other endocrine disease: yes / no
if yes:
specify:……
previously recorded diagnosis: yes / no,
if no: Date of diagnosis (year):……

Drugs taken for endocrine diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

<u>Neurologic or psychiatric disorder</u>

Epilepsy: yes/no
if yes:
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Depression: yes/no
if yes:
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Other neurologic or psychiatric disease: yes / no
if yes:
specify:……
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Drugs taken forneurologic or psychiatric diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..

active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Respiratory diseases

Asthma: yes/no
if yes:
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

COPD: yes/no
if yes:
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Other respiratory disease: yes / no
if yes:
previously recorded diagnosis: yes / no
if no: Specify:……
Date of diagnosis (year):……

Drugs taken for respiratory diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Malignant diseases

Present malignant disease: yes/no
if yes:
previously recorded diagnosis: yes / no
if no: Type:……
Date of diagnosis (year):……

Previous malignant disease: yes/no

if yes:
previously recorded diagnosis: yes / no
if no: Type:……..
Date of diagnosis (year):……

Have you ever receive chemotherapy? yes / no

if yes:

previously recorded data: yes / no
if no: when:……. occasions:……., active agent:…….

Have you ever receive radiotherapy? yes / no

if yes:

previously recorded data: yes / no
if no: when:……., dose:……sessions:…….

Have you ever receive immune thereapy? yes / no

if yes:

previously recorded data: yes / no
if no: when:……, active agent:……..

<u>Kidney disease</u>: Yes / No
if yes:
previously recorded diagnosis: yes / no
if no: Type:…….
Date of diagnosis (year):……

Drugs taken for kidney diseases:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

<u>Bleeding disorder:</u> Yes/No

if yes: specify:…….
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Drugs taken for bleeding disorder:

previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Drugs causing bleeding disorder

previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Systemic autoimmune disease Yes/No

if yes: Type:……
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Drugs taken for systemic autoimmune diseases:

previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Osteoporosis Yes/No

if yes:
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Drugs taken for osteoporosis, or affecting skeletal system

previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Allergy Yes/No
if yes: for what:……..
previously recorded diagnosis: yes / no
if no: Date of diagnosis (year):……

Drugs taken for allergy:
previously recorded medication: yes / no
if no:
Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

Oral diseases:
recurrant labial herpes: yes/no
if yes:
previously recorded diagnosis: yes / no

recurrent aphtha/ulcers: yes/no
if yes:
previously recorded diagnosis: yes / no

5. Re-evaluation of patient with OPMD:

Extraoral examination:

Lymph nodes: changes compered to previous examination: Y/N if yes where (multiple choice):

submental

submandibular: left/right

upper jugular: left/right

mid jugular: left/right

supraclavicular: left/right

paratracheal

posterior triangle: left/right

Quality of the palpated lymph node(s):

Surface: smooth/ rough

Mobility: mobile/fixed

Sensation: painful/ non painful

Texture: soft/solid

Size:……. mm x…… mm

Intraoral lesion:

Recurrence of previously excised lesion at the same site: Y/N, if yes describe according to first form:

New lesion at previously non affected site: Y/N, if yes describe according to first form:

Localisastion:

Bucca: left/right

Hard palate: left/right/both (over the midline)

Soft palate: left/right/both (over the midline)

Gingiva: upper/lower,buccal/oral, edentulous/dentulous,lateral region/ front region

Tongue: dorsal/ventral/lateral side: left/ right

Sublingual and paralingual area:left/ right/ both (over the midline)

Retromolar triangle: left/right

Palatoglossal arch: left/right

Palatopharyngeal arch: left/right

Uvula

Lip: upper/lower/both, left/right/ both (over midline), over vermillon border: Yes/No, commissure: left/right

Changes in non-excised lesion:

Lesion expansion/ growth in size: Y/N, if yes: new size: total change in size in mm:

Change in colour or pattern: Y/N if yes describe:

Change in shape: Y/N

Change in border: Y/N (from well demarcated to less/not demarcated)

Change in consistency: Y/N if yes describe:

Change in homogeneity: Y/N if yes describe:

Picture of the lesion (regardless of noticed change)

Picture of vital staining if performed: positive/negative

5.Dental status:

performed scaling and polishing Yes/no
improved oral hygene Yes/no
dental revisions: yes/no
removed amalgam fillings: yes/no If yes: all changed: yes/no
treated caries lesions: Yes/no if yes: all treated: yes/no
Dental foci: positive/negative If positive, lesion:
If dental revision was performed, is it complete: yes/no
/Completed dental revision (no caries lesions with cavitation, no dental foci, no ill-fitting denture/ restoration)/

6. Blood test performed: yes/no,

if yes:

Infalmmatory prameters:

We:……. mm/h

CRP:……... mg/l

Cellular components:

Haematocrit: ……%

Red blood cell:……. millio/µl

Thrombocyte number: ……. /µl

Leukocyte number:……../µl

Neutrophilgranulocyte: ……./µl

Lymphocyte:……../µl

Red blood cells:

Haemoglobin:……..g/dl

MCV:…….fl

MCH:…….pg

MCHC:……..g/dl

Metabolism:

se-glucose:…..mmol/l

HbA1C:…….%

se-uric acid:…… µmol/l

se-triglyceride:…..mmol/l

se-cholesterin:……..mmol/l

LDL:……..mmol/l

HDL:……..mmol/l

6. Therapy: yes/no, if yes:

Surgical:

Biopsy: yes/no if yes: incisional/ excisional

Laser ablation: yes/no

other: yes/no if yes describe:……..

Non surgical:

Non surgical:

Prescribed medication: yes/no

if yes:

retinoids: yes/no

if yes: Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

antifungal therapy: local/systemic

if yes: Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

desinfectant: yes/no

if yes: Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……
how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

other: yes/no

if yes: Name of medication:……..……..
active substance:……
dose: ……. (number only!)
unit: g / mg / IU
if fluid, concentration (e.g. 10%, 1g/2ml, etc.)……

how many times per day (e.g. 3): …….
Method of administration: N/A / intravenious / oral / enteral / subcutan
other notes: ……

8. Complications, adverse events, epicrisis

Complaints adverse effects of prescribed medication:

loss of taste sensation: yes/no

burning sensation: yes/no

other local sensation/sympthomes: yes/no

if yes: describe:

diarrhea: yes/no

vomiting: yes/no

other: yes/no

if yes: describe:……..

Death: yes / no

if yes: date: ……..

etiology: oral cancer related /other:……