
Logbook of

# Oral Medicine

Third year BDS

**Name: _____**

**Roll No: _____**

**Batch: _____**

**Rotation Dates: _____**

# Learning Outcomes for Oral Medicine

**By the end of clinical rotation in oral medicine, third-year students should be able to :**

- Demonstrated compliance with departmental rules and cross-infection control measures in the hospital.
- Practice the principles of ethics and patient care.
- Apply effective tools of communication during history, physical examination and other interactions with the patient and staff.
- Perform a detailed extraoral and intra-oral examination of the patient from an Oral Diagnosis point of view.
- Identify medically compromised conditions and their dental implications.
- Diagnose and manage common oral mucosal diseases, premalignant and malignant conditions, temporomandibular joint, and salivary gland disorders in patients of all ages.
- Differentiate between various types of orofacial pains (Odontogenic, nonodontogenic, psychogenic and neurogenic).
- Identify and manage oral manifestations of systemic diseases.
- Order and interpret different investigations (laboratory / radiographic) and establish a definitive diagnosis.
- Note the findings of patient's history and relate with clinical examination and investigation to formulate a diagnosis and treatment plan.
- Demonstrate the ability to diagnose medical emergencies and outline suitable management strategies.
- Recognized common occupational hazards in dentistry, including radiation exposure and needle-stick injuries, and demonstrated appropriate preventive measures.

# SOP ORAL MEDICINE

1. Students must be properly dressed and wear their overall/ coat with name plates and ID cards displayed.
2. All students must report to the department on time and mark their attendance every day.
3. Students need to attend specific demonstrations to be held by the department according to the timetable.
4. During rotation, each student must take history, do examinations and diagnose different patients within the clinical area.
5. Patients could be of facial or intra oral swelling, oral ulcers, Oro-facial pain, temporomandibular disorders and Oral ulcers.
6. Examination instruments will be provided by the department.
7. Students must bring their own BP apparatus, thermometer, stethoscope, torch and scale for physical examination.
8. Students would only be allowed to examine patients during their allocated clinical hours.
9. Students will be required to submit completed logbook at the end of rotation.

# CLINICAL TRAINING REQUIREMENTS (QUOTA)

1. Five histories, examination, diagnosis and management plan of different patients including at least one patient each from Facial or intra oral swelling, oral ulcers, Oro-facial pain and Temporomandibular disorders.

# FINAL ASSESSMENT:

Name.....Department.....

**Rating Scale;** A; Excellent. B; Very good. C; Good. D; Average. 5; Below average.

| S.No. | Performance | Rating | | | | |
|---|---|---|---|---|---|---|
| | | A | B | C | D | E |
| 1 | Punctuality | | | | | |
| 2 | Patient safety and Cross infection control measures | | | | | |
| 3 | Ethics/ Professionalism | | | | | |
| 4 | Communication Skills (oral, clinical notes) | | | | | |
| 5 | Effective team member, leadership quality | | | | | |
| 6 | Problem-Solving Skills, Collecting & analyzing patient info. Ability to link theory to Practice | | | | | |
| 7 | Clinical skills | | | | | |
| 8 | Clinical performance | | | | | |
| 9 | Patient Satisfaction | | | | | |
| 10 | Theoretical perspective | | | | | |

**Submission date:**

**General Remarks:**

.....

.....

**Overall Rating**; .....

Signature Head of Department:

## PROCEDURES LIST OF ORAL DIAGNOSIS & ORAL MEDICINE

| | **PROCEDURE** | **COMPETENCY** | | |
|---|---|---|---|---|
| | | **Observe** | **Perform under supervision** | **Perform independently** |
| **1.** | History taking | | | |
| **2.** | Clinical examination | | | |
| **3.** | Differential Diagnosis | | | |
| **4.** | Advising appropriate investigations(lab/radiographic) | | | |
| **5.** | Radiograph taking | | | |
| | Periapical | | | |
| | Panoramic Xray | | | |
| **6.** | Radiologic interpretation | | | |
| | Periapical | | | |
| | Panoramic x-ray | | | |
| | CBCT Scans | | | |
| **7.** | Definitive Diagnosis | | | |
| **8.** | Prescription writing | | | |
| **9.** | Referral of the patient to the relevant Department | | | |
| **10** | Writing appropriate Referral notes | | | |
| **11** | Treatment planning | | | |
| **12** | Miscellaneous | | | |

| Date | Name of patient | Patient ID | Procedure | Competency | Signature |
|---|---|---|---|---|---|
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**Referral Letter Template**

[Date]

**To:**

[Consultant's Name]
[Department Name]
[Hospital Name]

Dear Dr. [Consultant's Last Name],

**Re:** Referral for [Patient's Name], [Date of Birth: DOB]

I am referring [Patient's Name] to your clinic for further evaluation and management of [specific condition or concern].

**Clinical Details:**

- Presenting Complaint: [e.g., Persistent dental pain, limited mouth opening]
- Duration: [e.g., Symptoms have been present for __ months]
- Relevant Findings: [e.g., Significant weight loss, abnormal imaging findings]
- Past Medical History: [e.g., Hypertension, diabetes]
- Current Medications: [e.g., List of current medications]

**Investigations:**

- Recent Tests: [e.g., Blood tests, MRI, X-rays]
- Results: [e.g., Elevated liver enzymes, abnormal MRI findings]

**Reason for Referral:**

Due to [e.g., worsening symptoms, need for specialized evaluation], I would appreciate your expert assessment and management recommendations for this patient.

Enclosed are [e.g., relevant test results, imaging reports] for your review. Please do not hesitate to contact me if you require further information.

Thank you for your attention to this referral. I look forward to your evaluation and recommendations.

Yours sincerely,

[Your Full Name]
[Your Title]
[Your Contact Information]
[Your Department]

# CHECK LIST FOR HISTORY TAKING AND EXAMINATION

| DETAILED MEDICAL HISTORY | |
|---|---|
| a) CNS | |
| b) ENT | |
| c) Respiratory | |
| d) CVS | |
| e) GIT | |
| f) Dermatology | |
| g) Musculoskeletal system disorders | |
| h) STD, Urogenital | |
| i) HIV related symptoms | |
| i) Medication side effects, Allergies etc. | |
| j) Psychiatry | |
| k) Others (Allergies etc.) | |

| GENERAL PHYSICAL EXAMINATION | | | |
|---|---|---|---|
| **I. General** | | | |
| a. Gait | | g. Nails | |
| b. Build | | i. Sclera | |
| | | j. Conjunctiva | |
| d. Posture | | k. Pallor | |
| e. Skin | | l. Cyanosis | |
| f. Hair | | n. Edema | |
| | | | |

| **II. Vital Signs:** | |
|---|---|
| a. Blood Pressure | |
| b. Temperature | |
| c. Respiratory Rate | |
| d. Pulse Rate | |

| Extra oral Examination (Head and Neck) | |
|---|---|
| a. Face | |
| b. Skin | |
| c. Nose | |
| d. Eyes | |
| e. Ears | |
| f. TMJ | |
| g. Salivary Glands | |
| h. Lymph Nodes (Head and Neck) | |
| i. Others | |

| INTRAORAL EXAMINATION | |
|---|---|
| **I. Hard Tissue Examination** | |
| a. Teeth Present | |
| b. Missing Teeth | |
| c. Dental Caries | |
| d. Dental Caries with Pulpal Involvement | |
| e. Retained Roots | |
| f. Mobility (Periodontal involvement) | |
| h. Occlusion | |
| I. Deposits<br><br>j. Fractured Teeth<br><br>k. Others (hypoplasia, supernumerary teeth, malposition, etc.,) | |
| **II. Soft Tissue Examination** | |
| a. Gingiva | |
| b. Periodontal Pockets | |
| c. Buccal Mucosa | |
| d. Floor of the Mouth | |
| e. Vestibule | |
| f. Tongue | |
| g. Lips | |
| h. Palate | |
| i. tonsils | |
| j. Oropharynx | |
| k. salivary papilla | |

# Logbook Entry No. _____

**DATE:** _____

**Name of Patient:** _____ **Age:** _____
**S/o, D/O, W/O:** _____ **Sex:** _____ **Contact no.:** _____
**Address:** _____

**HISTORY SHEET**

**PRESENTING COMPLAINTS:** **Duration:**
**1.** _____ _____
**2.** _____ _____
3. _____ _____

**HISTORY OF PRESENTING COMPLAINT:** _____
_____
_____

**PAST DENTAL HISTORY:** _____
_____

**PAST MEDICAL HISTORY:** _____
_____

**DRUG HISTORY:** _____
**Drug Allergies: (if any)** _____
**Current Medication:** **Dosage:**
**1.** _____ _____
**2.** _____ _____
**PAST SURGICAL HISTORY:**

**ALLERGIES:**
**FAMILY HISTORY:** _____

**PERSONAL HISTORY:**
**Sleep:** _____ **Appetite:** _____
**Bowel:** _____ **Micturition:** _____
**Marital Status:** _____ **Habits:** _____
**Occupation:** _____ **Socio-Economic Status:** _____
**MENSTRUAL HISTORY:**

**GENERAL PHYSICAL EXAMINATION:**
**Height** _____ **Weight** _____ **Built** _____
**General Physical Appearance:** _____
**Abnormal Findings:** _____

**VITAL SIGNS:**
**Pulse Rate:** _____ **Blood Pressure:** _____
**Temperature:** _____ **Respiration Rate:** _____

## LOCAL EXAMINATION

### EXTRAORAL EXAMINATION:

**INSPECTION:**

**Asymmetry:** _____ **Scars / Hematoma:** _____

**Mouth Opening:** _____ **Eye Movements:** _____

**Abnormal Findings:** _____

_____

**PALPATION:**

**Tenderness:** _____

**Lymph nodes Examination:** _____

_____

**Abnormal Findings:** _____

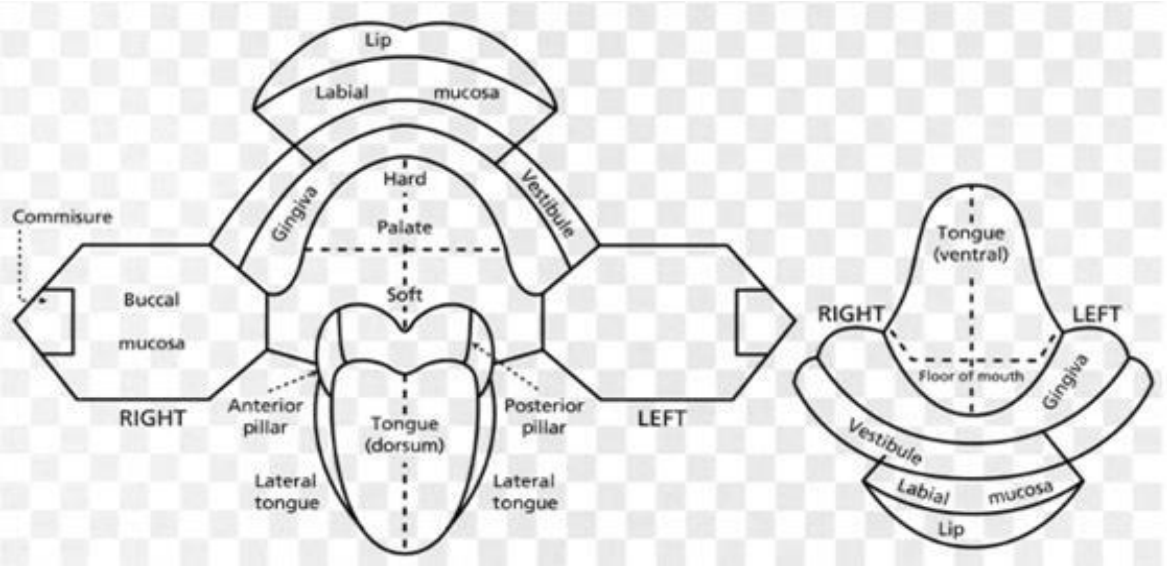
_____

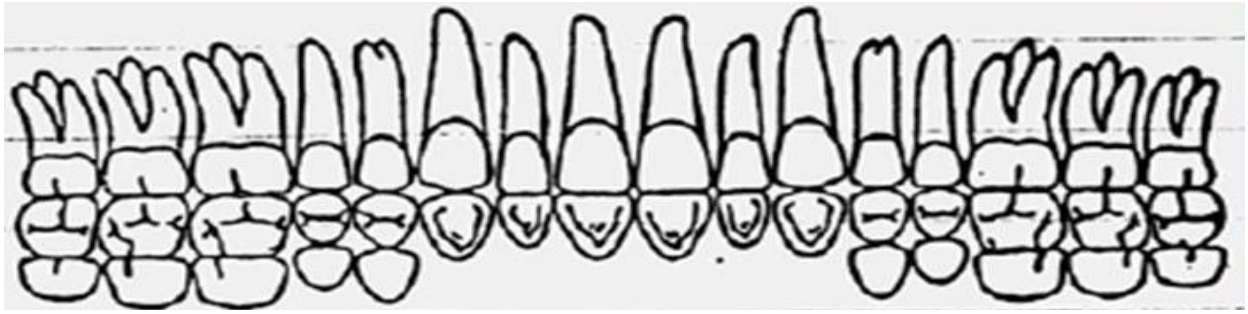
**TMJ EXAMINATION:**

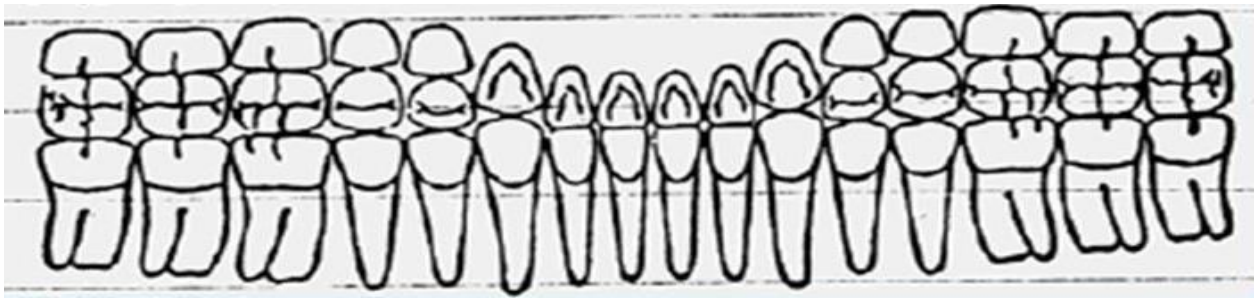
_____

_____

### INTRAORAL EXAMINATION:







**SEQUENCE:** Inspection ⟶ Palpation ⟶ Percussion ⟶ Auscultation

**SOFT TISSUE:**

_____

_____

_____

**HARD TISSUE:**

_____

_____

_____

**TEETH:**

_____

_____

_____

**DIFFERENTIAL DIAGNOSIS :**

1. _____
2. _____
3. _____

**INVESTIGATIONS:**

**IMAGING:**

_____

_____

**LABORATORY INVESTIGATIONS:**

_____

_____

**OTHERS:** (Biopsy/C&S)

_____

_____

_____

**DIAGNOSIS:**

_____

_____

**MANAGEMENT PLAN:**

1. _____
2. _____
3. _____
4. _____
5. _____

**PRESCRIPTION:**

_____

_____

_____

_____

_____

**SPECIAL INSTRUCTIONS:**

_____

_____

**FOLLOW UP:**

_____

**APPROVED** _____ **DATE** _____

**CHECKED BY:** _____ **SIGN & STAM:** _____

**REFERRAL LETTER**

**Date** _____
**To:**

_____
_____
_____

**Dear Dr**. _____
**Re:** _____, Date of Birth: _____
_____
_____

**Clinical Details:**

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_____

_____

**Investigations:**

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_____

**Reason for Referral:**

_____

_____

_____

**Remarks:**

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**Full Name:** _____

**Title:** _____

**Contact Information:** _____

**Department:** _____

**Hospital:** _____