

**Patient Presentation – History & Physical**  
**Oral and Maxillofacial Surgery**  
**OSG 831/841**

The following is offered to enable students in the third and fourth year Oral & Maxillofacial Surgery clinical rotations to better prepare themselves for proper oral presentation of patients. This format provides students with an outline for improved communication regarding patient information with dental and medical colleagues. During your two week rotation in Oral and Maxillofacial Surgery, patient presentations should be as follows:

- 1) **CC:** The *chief complaint* is to be reported in the patient's own words and is the patient's statement as to why he or she reported for healthcare.
- 2) **HPI:** The *History of Present Illness* is intended to represent the recent history of the patient's chief complaint. This section should also include important aspects of the patient's history relative to the chief complaint. For example, if the patient reports for pain and swelling of the face, related to a previous toothache, History of Present Illness will include duration of pain and swelling, any previous treatment such as antibiotics or root canal therapy, as well as fever, chills, nausea, vomiting, inability to swallow, or inability to breathe.
- 3) **PMH:** This section is the patient's *Past Medical History*. In this section specific disease processes should be listed with a brief description of their treatment along with date of diagnosis. For example:
  - a) Diabetes mellitus-diagnosed at the age of 35 and controlled with oral hypoglycemics.
  - b) Asthma-diagnosed in early childhood. Patient currently takes meter dosed inhaler of Albuterol PRN. Last attack was six months ago. The patient has no hospital admissions for asthma.
  - c) HTN-Patient was diagnosed with hypertension approximately six months ago and is currently not taking any medications.
- 4) **PSH:** The *Past Surgical History* should be used to list the patient's previous surgeries along with the date and any note of complications. For example:
  - a) Tonsillectomy – age 12; no complications.
  - b) Appendectomy -- age 16; no complications.
- 5) **Meds: Medications** should be listed with the dosages and dosing schedules. For example:
  - a) Lortab 5, 1-2 tabs po q 4-6 hours prn pain
  - b) Pen VK 500 mg, 1 tab po q 6 hours until all taken
  - c) Metoprolol 50 mg, 1 tab po BID.

- 6) **Allergies:** Please list any drug allergies along with reported reaction. If the patient has no allergies, please state “no known drug allergies” (NKDA).
- a) penicillin—hives
  - b) codeine—severe nausea and vomiting
- 7) **SH: *Social History*** is important to elucidate pre-dispositions to infectious disease. In addition, it is also important to elucidate behavior that can be detrimental to the long-term health of the patient and wound healing. For this reason in this category we list tobacco history to be reported as pack years (number of packs per day times number of smoking years). In addition, an attempt should be made to quantitate number of alcoholic drinks the patient has per week. Finally note should be taken of the patient’s history of intravenous drug use, illegal drug abuse, history of blood transfusions, and history of any tattoos.
- a) 1 pack per day smoking history for 10 years (or 10 pack year history)
  - b) 12-pack of beer per week
  - c) denies IVDA
- 8) **ROS:** This section is the ***Review of Systems***. This section is not to restate elements already included in the patient’s past medical history. It is, however, intended to review the patient’s current physical status. This means that any current symptoms that the patient is having should be noted, along with including any pertinent negatives. This section would take note of any pain, fever, chills, nausea, vomiting, current chest pain, current shortness of breath, current abdominal pain or any changes in bodily habits, etc. Again, these questions are grouped into systemic categories.
- 9) **PE:** This is the ***Physical Examination*** section. For most clinic patients, this is limited to the head and neck region. Once the head and neck exam has been mastered, a relatively thorough exam can be accomplished within minutes. This should be accomplished on all clinical patients prior to any treatment. A very quick exam of the head, including scalp and facial skin as well as symmetry of the face (upper and lower) can be conducted during introductions with the patient. Observation of the patient’s extraocular muscle function and neck range of motion should be noted. Following this, the patient’s neck, including supraclavicular and suprasternal areas, should be palpated for detection of any possible nodes or masses. Maximum incisal opening should be roughly established. Bilateral temporomandibular joints should be palpated during opening and closing and any joint sounds should be noted. The floor of the mouth should be palpated bi-manually to detect any masses or inflammation of salivary glands. Likewise, the tongue should be palpated and the posterior pharynx should be visualized for any significant findings. Following this an exam of the patient’s oral mucosa starting with the lips, followed by the maxillary and mandibular vestibule and buccal mucosa, floor of the mouth, and lateral borders of the tongue should be completed looking for any masses or mucosal lesions. Finally, the teeth should be examined with the area of interest

being saved for the end of the exam so that no other significant findings are missed. All of these things should be included in the physical exam write up.

- 10) **X-rays:** Review of any applicable radiographic findings are included here. Thoroughness would dictate mention of bilateral temporomandibular joints, appearance of the bone in the mandible and maxilla, appearance of the maxillary sinuses and nasal cavity to include the nasal septum, and finally condition of the teeth and alveolar bone. Obviously any pathologic process should be noted.
- 11) **Assessment:** Please list diagnoses here by number. For example:
- a) Acute periapical periodontitis tooth number 21.
  - b) Generalized advanced periodontal disease.
- 12) **Plan:** Please include here any sedation or anesthesia to be given as well as plan of antibiotic coverage or other medications to be administered. Any pre-treatment lab values or additional x-rays that may be indicated would also be noted here. In addition, please include any plan for pre-operative medical evaluation or testing.

The above format should be followed for each new patient seen in the clinic. If the patients have ongoing treatment in the student clinic, and this complete exam has been previously stated in the record, it is not necessary to rewrite it again just so the patient can undergo an oral surgical procedure. However, notes should be made prior to the procedure that medical history and exam have been updated, with notation made of any changes. For each new clinic walk-in patient, the above should be done completely.

If you have any questions regarding this format, please address them to [Reena M. Talwar, DDS, PhD at 859-323-8749 or rmtalw2@email.uky.edu](mailto:Reena.M.Talwar@uky.edu) Rich Haug [rhhaug2@uky.edu](mailto:rhhaug2@uky.edu)