Medical/Dental Evaluation Data Sheet

Name______________________ **Date of Procedure**_____________

Type of Dental Procedure(s):

Cleaning _______
Exam _______
Filling _______
Extraction (specify # of teeth) _______
Other _______

List type, dose, and time of behavioral medication_______________________________

Dental Wrap? Y* N (*if 'yes'- amount of time in dental wrap) __________ mins.

Hands-on intervention necessary to complete procedure? Y* N
(*Total duration of hands-on intervention _________ mins.)

Behavior Rating During the Procedure

	Not at all	Some	half the time	most of the time	all the time
1) resisting procedure	0	1	2	3	4
2) attempt to leave chair	0	1	2	3	4
3) aggressive behavior	0	1	2	3	4

Comments about
Behavior____
____
____
____

Was procedure able to be done?____________________________________

Suggestions by medical/dental practitioner for future visits:

_______________________________ _______________
Staff Date

Revised 7/20/12