Assessment of Treatment Needs

Primary responsibility: Clinician/Surgeon
Timing: At recall visit
Location: Chairside
Patient/date:

Patient Symptoms

☐ Yes ☐ No Soreness, discomfort, and/or pain

☐ Yes ☐ No Bleeding and/or suppuration

☐ Yes ☐ No Implant and/or prosthesis mobility

☐ Yes ☐ No Swelling and/or recession

☐ Yes ☐ No Unsatisfying soft tissue esthetics

☐ Yes ☐ No Bad breath (halitosis)

Clinical/radiographic observations

☐ Yes ☐ No Swelling and/or recession

☐ Yes ☐ No Inflammation, bleeding and/or suppuration

☐ Yes ☐ No Implant and/or prosthesis mobility

☐ Yes ☐ No Marginal bone loss

☐ Yes ☐ No Peri-implant radiolucency

☐ Yes ☐ No Parafunction

☐ Yes ☐ No Poor oral hygiene

☐ Yes ☐ No Bad breath (halitosis)

Action needed

☐ Yes ☐ No Regular follow-up

☐ Yes ☐ No Special attention

☐ Yes ☐ No Treatment