1. Patient personal details

Country:

City:

Hospital:

Doctor:

Insurance number:……..

Name:……

Date of birth:…….

Contact number:……..

Gender: Female / Male

Ethnicity/Race: White / Roma / Black / Indian / Asian / Other: …….

Was written consent given? Yes / No

Date:…….

2. Details from the medical history / Risk factors

Habits

Have you ever smoked tobacco products? yes / no
if yes:
Form: cigarette/ cigar/ cigarillo/ pipe/hookha/ reverese smoking /e-cigarette/ other:……. (multiple choice)
Filtered/ unfiltered/N.a (for each selected form)

Smoking presently:
yes / no
if yes: cigarette/ cigar/ cigarillo/ pipe/hookha/ reverese smoking/ e-cigarette/ other:……. (multiple choice)

Filtered/unfiltered/N.a (for each selected form)
amount (cigarettes or occasion/day):……
For how many years? ……
age at first use:……

if not:
Did you smoke earlier? yes / no
if yes: cigarette/ cigar/ cigarillo/ pipe/hookha/ reverese smoking/e-cigarette/ other:…….(multiple choice)

filtered/unfiltered/ NA (section filled in for each type separately)
if yes: amount (cigarette or occasion/day): ……
For how many years?……
Age at first use:…….
How long ago did you stop smoking? …….(év/hónap/hét/nap)

Have you ever used smokeless tobacco products? yes / no
if yes:
Form: chewing tabacco/ Snuff/ Snus/ Dip/ other:……..

Do you presently use any?: yes / no
if yes:
Form: chewing tabacco/ Snuff/ Snus/ Dip/ other:……..

frequency: occasional/ monthly/ weekly/ daily (section filled in for each type separately)
amount (/occasion):……
For how many years? ……
age at first use:…….

if not:
Did you use earlier? yes / no
chewing tabacco/ Snuff/ Snus/ Dip/ other:……..
if yes: frequency: occasional / monthly / weekly / daily
amount (/occasion):……
For how many years?……
How long ago did you stop using? …….
age at first use:…….

Alcohol consumption (present): yes / no
if yes: what form? spirit drink/ wine/ beer / other:……(multiple choice)
frequency: occasionally/monthly/weekly/daily
amount (g/day):……
since when? (years):…….
Alcohol consumption in the last 2 weeks: ……..
if not:
Did you drink alcohol earlier? yes/no
if yes: what form? spirit drink/ wine/ beer / other:……(multiple choice)
frequency: occasionally/monthly/weekly/daily
amount (g/occasion):……
For how many years?……
How long ago did you stop drinking alcohol?.....

<u>Guide for estimation of the amount:</u>
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

Caffeine consumption : yes /no

if yes, in what form do you consume caffeine? Coffe/instant coffee/ black tea/ green tea/ white tea/ energy drink/ coke/ coffeine tablet (multiple choice)

Coffee: yes / no
if yes,
how often do you consume coffee? occasionally/monthly/weekly/daily
How much do you consume?.....
(1 dose = one espresso or long coffe)

Instant Coffee: yes / no
If yes,
how often do you consume instant coffee? occasionally/monthly/weekly/daily
How much do you consume?.....
(1 dose = one packet)

Tea (black or green): yes / no
If yes, type: black / green / white / oolong
how often do you consume tee? occasionally/monthly/weekly/daily
How much do you consume?.....
(1 dose =2 dl)

Energy drink: yes / no
If yes,
how often do you consume energy drink ? occasionally/monthly/weekly/daily
How much do you consume?.....
(1 dose = 2,5 dl)

Cola: yes / no
If yes, how often do you consume coca-cola? occasionally/monthly/weekly/daily
How much do you consume?.....
(1 dose =3,3 dl)

Caffeine tablet: yes / no
If yes,
how often do you consume caffeine tablet? occasionally/monthly/weekly/daily
How many do you consume?.....
(1 dose =1 tablet= 100 mg)

Drug abuse: yes/no *Prescribed medication should not be included here.*
if yes: type of drug:…….
amount:…….
for how many years:……
If not: did you use earlier? yes/no
if yes: type of drug:…….
amount:…….
for how many years:……

How long did you stop?.....

3. Diseases and medications:

Cardiovascular diseases

Hypertension: yes/no
If Yes: Date of diagnosis (date: year)…….

Arrhythmia: yes/no
If Yes: Date of diagnosis (date: year)…….

Atherosclerosis: yes/no
If Yes: Date of diagnosis (date: year)…….

Other cardivascular disease: yes / no
If Yes: Specify:……
Date of diagnosis (date: year)…….

Drugs taken for cardiovascular diseases:
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

Hepatitis B infection: yes/no
If Yes: Date of diagnosis (date: year)…….
Treatment: yes/no
if yes: name of medication:……
start of treatment: (date)
end of treatment: (date)

Hepatitis C infection: yes/no
If Yes: Date of diagnosis (date: year)…….
Treatment: yes/no
if yes: name of medication:……
start of treatment: (date)
end of treatment: (date)

treatment result: SVR / non-responder

HIVs: yes/no
If Yes: Date of diagnosis (date: year)…….

HPV: yes/no
If Yes: Date of diagnosis (date: year)…….

Other chronic infectious disease: yes/no
If Yes: Specify:……..
Date of diagnosis (date: year)…….

Drugs taken for infectious diseases:
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: Date of diagnosis (date: year)…….

Crohn disease: yes/no
If Yes: Date of diagnosis (date: year)…….

Colitis ulcerosa: yes/no
If Yes: Date of diagnosis (date: year)…….

IBD: yes/no
If Yes: Date of diagnosis (date: year)…….

Gluten intolerance/Coeliac disease: yes/no
If Yes: Date of diagnosis (date: year)…….

Lactose intolerance: yes/no
If Yes: Date of diagnosis (date: year)…….

Other gastrointestinal disease: yes/no
If Yes: Specify:……
Date of diagnosis (date: year)…….

Drugs taken for GIT diseases:

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: ……

Endocrinopathy

Diabetes mellitus: yes/no
If Yes: Type: I / II / IIIc / MODY
Date of diagnosis (date: year)…….

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

Other endocrine disease: yes / no
If Yes: Specify:…….
Date of diagnosis (year):……

Drugs taken for endocrine diseases:
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: ……

Neurologic or psychiatric disorder

Epilepsy: yes/no
If Yes: Date of diagnosis (date: year)…….

Depression: yes/no
If Yes: Date of diagnosis (date: year)…….

Other neurologic or psychiatric disease: yes / no
If Yes: Specify:…….
Date of diagnosis (year):……

Drugs taken forneurologic or psychiatric diseases:
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: Date of diagnosis (date: year)…….

COPD: yes/no
If Yes: Date of diagnosis (date: year)…….

Other respiratory disease: yes / no
If Yes: Specify:…….
Date of diagnosis (year):……

Drugs taken for respiratory diseases:
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: type:…….
Date of diagnosis (date: year)…….

Previous malignant disease: yes/no
If Yes: type:……..
Date of diagnosis (date: year)…….

Have you ever receive chemotherapy? yes / no

if yes: when:……. occasions:……., active agent:……

Have you ever receive radiotherapy? yes / no

if yes: when:……., dose:……sessions:…….

Have you ever receive immune thereapy? yes / no

if yes: when:……, active agent:……..

<u>Kidney disease</u>: Yes / No
if yes: what type:……..

Drugs taken for kidney diseases:
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: etiology:……

Drugs taken for bleeding disorder:
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
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>Systemic autoimmune disease</u> Yes/No
if yes what type:…….

Drugs taken for systemic autoimmune diseases:
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

Drugs taken for osteoporosis

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:……..

Drugs taken for allergy:

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
recurrent aphtha/ulcers: yes/no

4. Complaints related to the oral cavity

Is this the first visit related to the lesion in our clinic? yes/no

if no:

First visit: ……(date)
Previous biopsy from the lesion: yes/no
if yes: date:.....
Previous non surgical therapy for the lesion: yes/no

if yes:
type (multiple choice): antifungal / retinoid / desinfection / other:…….
method of administration (for each therapy multiple choice):
local / systemic
active agent:……..
length of therapy: ……days/week/month/year

if yes:
Did you notice the oral mucosal lesion? yes/no
if no: who did? dentist / GP / other doctor or specialist / other:……
date of referral/diagnosis:……..
if yes (you noticed it first):
when did you notice it? ……(date)
Did its grow/expand/ spread since the first notice diagnosis? yes/no
Did you have any symptomes related to the lesion? yes/no
if yes: type (multiple choice): pain / discomfort / bleeding / bad breath/ other:….

Current symptoms, complaints:

Pain: Yes/no

if yes: symptom severity: mild / moderate / severe

Burning sensation: Yes/no

if yes: symptom severity: mild / moderate / severe

Discomfort: Yes/no

if yes: symptom severity: mild / moderate / severe

Itching sensation: Yes/no

if yes: symptom severity: mild / moderate / severe

Dry mouth (xerostomia): Yes/no

if yes: symptom severity: mild / moderate / severe

Bad breath (halitosis): Yes/no

if yes: symptom severity: mild / moderate / severe

Bad taste sensation: Yes/no

if yes: symptom severity: mild / moderate / severe

Bleeding while brushing the teeth: Yes/no

if yes: symptom severity: mild / moderate / severe

Difficulty swallowing: Yes/no

if yes: symptom severity: mild / moderate / severe

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

5. Examination:

Extraoral:

Lymph nodes in the head and neck region:
Palpation: positive / negative
if positive: 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 examination:

Localisation: (mark the affected structures multiple choices available)

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

Colour (multiple options)

red/white/brown/blue/yellow/ other: .....

Amount:

singular/multiple

Size: (area affected if multiple at same site)

width maximum* length maximum

Borders:

well demarcated/poorly demarcated

Shape:

regular/irregular

Consistency:

soft/firm

Character and surface

macule (flat)/ depressed/ raised

homogen /inhomogen

Tenderness on palpation: yes/no

Dentition (multiple options possible)

intact dentition

partially edentulous (upper/lower)

totally edentulous (upper/lower)

amalgam filling(s)

composite fillings (s)

cobalt-chrome containing crown

full ceramic restoration(s)

partial removable denture (acrylic-metallic)

complete removable denture (acrylic)

implant(s)

active caries leson(s):

gingivitis:

periodontitis:

oral hygiene: excellent/good/bad/completely neglected

Picture of the lesion, lesions:

Light detection used: yes/no

if yes: type of system used:……

positive/negative

if positive: picture:

Vital staining: yes/no

if yes: toluidin blue / methylene blue / iodine

positive/negative

if positive: picture:

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

Creatinine:……umol/l

7. Therapy:

Surgical: yes/no

if yes: **Biopsy:** yes/no

if yes: incisional/ excisional

Laser ablation: yes/no

other: yes/no

if yes describe:……..

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. Epicrisis

After a week

Form of contact: on phone / in person

Complications related to the biopsy:

pain: yes/no

bleeding: yes/no

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:……