Firstname	**Lastname**	**HAS ID** ____ ____ _____ ____ ____

Date	**O Male O Female**	**DoB**	**Age (years) O Not sure**
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	
Cell phone number		**Number is O Athlete's O Parent's / Guardian 's**	
Providing a phone number is optional. It will be used to send a text reminder if any follow up is recommended after screening.			

Screener's name

Dental History

1. Fill out this section for each athlete even if edentulous

How often do you clean your mouth?

O Once or more a day
O 2 to 6 times per week
O Once per week
O Less than once per week
O Not sure

2. Pain inside mouth

O Yes O No
☐ Teeth
☐ Other

3. ☐ Athlete refused/could not screen

Screening

4. Edentulous

O Yes **(-> stop here)** ☐ **Exam completed**
O No **(answer all questions 5 thru 14)**

5. Untreated decay

O Yes O No
☐ Anterior(s)
☐ Premolar(s)
☐ Molar(s)

6. Filled teeth

O Yes O No

7. Missing teeth

O Yes O No
☐ Anterior(s)
☐ Molar(s)

8. Sealant(s)

O Yes O No

9. Injury

O Yes O No
Injury Treated o Yes o No

10. Fluorosis

O Yes O No

11. Gingival signs

O Yes O No

12. Treatment urgency

O Maintenance
O Non-urgent
O Urgent

13. Mouthguard recommended

O Yes O No
☐ Mouthguard delivered

14. Fluoride Varnish recommended

O Yes O No
☐ Fluoride Varnish delivered