

Patient: \_\_\_\_\_ geb: \_\_\_\_\_ Zimmer: \_\_\_\_\_

Datum: _____ Uhrzeit: _____ Lippen: trocken <input type="checkbox"/> rissig <input type="checkbox"/> Rhagaden <input type="checkbox"/> <span style="float: right;">😊 😐 😞</span> Schleimhäute: trocken <input type="checkbox"/> Sonstiges _____ Zunge: trocken <input type="checkbox"/> belegt <input type="checkbox"/> Sonstiges _____ Pilz: gen. <input type="checkbox"/> lok. _____ Borken <input type="checkbox"/> Zahnfleisch: entzündet gen. <input type="checkbox"/> lok. _____ Druckstelle _____ Beläge Zähne: <span style="display: inline-block; text-align: center; margin-right: 10px;">😊 <input type="checkbox"/></span> <span style="display: inline-block; text-align: center; margin-right: 10px;">😐 <input type="checkbox"/></span> <span style="display: inline-block; text-align: center; margin-right: 10px;">😞 <input type="checkbox"/></span> TP <input type="checkbox"/> Tot <input type="checkbox"/> getragen? j <input type="checkbox"/> n <input type="checkbox"/> Sonstiges _____ Beläge ZE: <span style="display: inline-block; text-align: center; margin-right: 10px;">😊 <input type="checkbox"/></span> <span style="display: inline-block; text-align: center; margin-right: 10px;">😐 <input type="checkbox"/></span> <span style="display: inline-block; text-align: center; margin-right: 10px;">😞 <input type="checkbox"/></span> ZE OK <input type="checkbox"/> <input type="checkbox"/> j <input type="checkbox"/> n <input type="checkbox"/> _____ ZE UK <input type="checkbox"/> <input type="checkbox"/> j <input type="checkbox"/> n <input type="checkbox"/> _____ Zst <input type="checkbox"/> Vopr <input type="checkbox"/> PSI <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center; width: 30px; height: 20px;"><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table> sK _____ Mu _____ üZ <input type="checkbox"/> Exz2 _____ <div style="border: 1px solid black; height: 60px; margin-top: 10px;"></div>							<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="font-size: small;">Bs1-5</td><td> </td></tr> <tr><td style="font-size: small;">PBA1a/b</td><td> </td></tr> <tr><td style="font-size: small;">SP1a/b</td><td> </td></tr> <tr><td style="font-size: small;">PBa/b</td><td> </td></tr> <tr><td style="font-size: small;">WG 78</td><td>___/___</td></tr> <tr><td style="font-size: small;">(PB)Zst</td><td> </td></tr> <tr><td style="font-size: small;">Vopr</td><td> </td></tr> <tr><td style="font-size: small;">PSI</td><td> </td></tr> <tr><td style="font-size: small;">Mu</td><td> </td></tr> <tr><td style="font-size: small;">sK</td><td> </td></tr> <tr><td style="font-size: small;">üZ</td><td> </td></tr> <tr><td style="font-size: small;">Exz2</td><td> </td></tr> <tr><td style="font-size: small;">Ä70</td><td> </td></tr> <tr><td colspan="2" style="text-align: center; font-weight: bold; font-size: small;">2. Besuch?</td></tr> <tr><td style="font-size: x-small;">Dat</td><td style="font-size: x-small;">Zeit</td></tr> <tr><td> </td><td> </td></tr> <tr><td style="font-size: small;">Bs1-5</td><td> </td></tr> <tr><td style="font-size: small;">PBA1a/b</td><td> </td></tr> <tr><td style="font-size: small;">SP1a/b</td><td> </td></tr> <tr><td style="font-size: small;">PBa/b</td><td> </td></tr> <tr><td style="font-size: small;">WG 78</td><td>___/___</td></tr> </table>	Bs1-5		PBA1a/b		SP1a/b		PBa/b		WG 78	___/___	(PB)Zst		Vopr		PSI		Mu		sK		üZ		Exz2		Ä70		2. Besuch?		Dat	Zeit			Bs1-5		PBA1a/b		SP1a/b		PBa/b		WG 78	___/___
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Dokumentation Reihenuntersuchung

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