MARVIX AI

SAMPLE ORAL PAIN EVALUATION SOAP NOTE

BURNING MOUTH — MULTIFACTORIAL (B12/IRON DEFICIENCY, CANDIDIASIS, XEROSTOMIA)

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Diane R. Whitfield
DATE OF SERVICE	06/18/2026
DOB	02/24/1962
PROVIDER	Dr. Priya Raghunathan, DDS, MD — Oral Medicine
AGE / SEX	64 / Female
CREDENTIALS	DDS, MD, Diplomate ABOM
MRN / PATIENT ID	OM-40915b
VISIT TYPE	Oral Pain Evaluation (new referral)

REFERRAL SOURCE

Referred by Dr. H. Osei (PCP) for a 5-month history of oral burning; also seen twice by her general dentist with no dental cause found.

DENTAL / PRIMARY CARE PROVIDER

Dentist: Dr. L. Marchetti, DDS · PCP: Dr. Henry Osei, MD (internal medicine)

CC CHIEF COMPLAINT

2 PRIMARY ORAL PAIN CONCERN

> *'My whole mouth burns like I scalded it with coffee — my tongue is the worst. It's been going on for months and nothing my dentist did helped. Some days I can barely taste my food.'*

Duration: Diane describes a persistent bilateral burning of the tongue, lips, and anterior palate present for approximately 5 months, gradually worsening. She was evaluated twice by her dentist (03/2026, 04/2026); a full dental exam and a periapical series showed no odontogenic source, and she was referred on for oral medicine evaluation. She reports the burning is now 'there most of the day, every day,' with additional dryness and an altered, metallic taste.

S SUBJECTIVE

3 PATIENT-REPORTED PAIN HISTORY

3a ONSET, COURSE, LOCATION & RADIATION

- **Onset:** Gradual, ~5 months ago (late January 2026). No precipitating dental work, trauma, new denture, or illness identified at onset. No cold-sore prodrome; no vesicles ever noted.
- **Location:** Bilateral, symmetric — anterior two-thirds of the tongue (worst), lower lip mucosa, and anterior hard palate. She denies unilateral pain, tooth-localized pain, or jaw/TMJ pain.

- **Course & timing:** Present most of the day; characteristically **milder on waking and worse as the day progresses** and worse in the evening — a pattern typical of burning mouth symptoms. Eating and cold drinks transiently relieve it; talking for long periods and spicy/acidic foods aggravate it.

3b PAIN QUALITY, SEVERITY & MODIFYING FACTORS

- **Quality & severity:** Burning / scalding, with superimposed rawness and tingling of the tongue tip. Average 5/10, up to 7/10 in the evening; rarely fully absent. Denies sharp, electric, or shooting pain (no features of trigeminal neuralgia).
- **Aggravating:** Spicy/acidic foods, carbonated and alcoholic drinks, prolonged speaking, stress, and toward end of day. **Relieving:** cold water, ice chips, chewing gum, and eating (a classic feature that argues against a primary mucosal lesion driving the pain alone).
- **Associated:** Persistent dry mouth, thick saliva, a metallic/altered taste, and intermittent tongue-tip tingling. Denies numbness, weakness, ulcers she can see, bleeding, or facial swelling.

3c RELEVANT HISTORY

- **Dental / oral history:** Partial upper denture worn ~4 years, fit 'a little loose' but pain is not limited to denture-bearing areas. Reports she often does not remove the denture overnight. No recent dental work, extractions, or new appliances. History of occasional tongue 'soreness' that she attributed to spicy food.
- **Medical history:** Type 2 diabetes (HbA1c trending up), hypothyroidism, hypertension, generalized anxiety, GERD, and post-menopausal status (menopause age 51). Prior gastric issues; remote history of iron-deficiency anemia. No known autoimmune disease.
- **Medication / exposure history: Amitriptyline 25 mg nightly** (for sleep/anxiety) and **sertraline 100 mg** — both xerostomic; **hydrochlorothiazide 25 mg** — xerostomic/diuretic; metformin 1000 mg BID; levothyroxine 88 mcg; omeprazole 20 mg daily (long-term — associated with B12 malabsorption). Never-smoker. Alcohol 3–5 glasses of wine/week. No vaping or betel nut.
- **Prior evaluation & treatment:** Two dental exams with periapical series — no odontogenic cause. Tried OTC benzocaine gel (transient relief) and a chlorhexidine rinse (worsened burning/staining). No prior labs directed at oral burning; no prior antifungal trial.

3d PERTINENT NEGATIVES

Denies any visible non-healing ulcer, rapidly enlarging lesion, unexplained bleeding, neck mass, facial weakness or numbness, dysphagia, odynophagia, trismus, fever, or unintentional weight loss. No red-flag features on history.

ROS ORAL PAIN REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Oral burning / soreness:** POSITIVE — bilateral tongue, lip, and anterior palate; 5–7/10, worse in evening
- **Tongue tip tingling:** POSITIVE — mild, intermittent; NO true numbness or paresthesia
- **Ulcers / vesicles / bleeding:** NEGATIVE by history — no visible ulceration or bleeding
- **Dysphagia / odynophagia / trismus:** NEGATIVE
- **Dry mouth / altered taste:** POSITIVE — persistent xerostomia and metallic dysgeusia
- **Tooth / jaw / TMJ pain:** NEGATIVE — no localized dental pain, no jaw or TMJ symptoms
- **Electric / shooting pain:** NEGATIVE — no trigeminal-neuralgia features
- **Systemic:** NEGATIVE for fever, weight loss, night

- **Dysphagia / odynophagia / trismus:** NEGATIVE
- **Systemic:** NEGATIVE for fever, weight loss, night sweats; POSITIVE for fatigue (chronic)
- **Exposures:** Never-smoker; moderate alcohol; no vaping / betel nut

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE	BLOOD PRESSURE
36.8°C — afebrile	134/84 mmHg
PAIN SCORE	**WEIGHT / BMI**
5/10 at rest; 7/10 by evening (patient report)	171 lbs / BMI 29.1 — stable, no loss

5a EXAMINATION

- **General appearance:** Well-appearing, mildly anxious, fully communicative. No facial asymmetry, distress, or discomfort with speaking or swallowing during the visit.
- **Extraoral:** No facial swelling or skin lesions. No cervical or submandibular lymphadenopathy. Salivary glands non-tender, no enlargement. TMJ non-tender with full mandibular range of motion. Cranial nerves V and VII grossly intact; no facial sensory deficit.
- **Intraoral — lips/mucosa:** Mild angular cheilitis bilaterally (erythema and fissuring at commissures). Labial mucosa mildly erythematous, no ulceration.
- **Intraoral — tongue: Erythematous, mildly depapillated (atrophic) dorsal tongue** with a smooth glossy appearance and scalloped lateral borders. Removable **white pseudomembranous plaques on the posterior dorsum and palate that wipe off leaving an erythematous base** — consistent with candidiasis. No indurated ulcer, no fixation, no mass.
- **Intraoral — palate/denture:** Erythema of the denture-bearing hard palate (denture stomatitis pattern). Upper partial denture slightly loose; no sharp flanges or focal trauma point correlating to the burning distribution.
- **Salivary flow:** Visibly reduced — frothy, scant pooled saliva; mucosa tacky; mirror sticks to buccal mucosa. Estimated hyposalivation.

PC PAIN CHARACTERIZATION / DIAGNOSTIC CONSIDERATIONS

6 SUSPECTED PAIN PATTERN

The presentation is **multifactorial burning mouth**, best understood as **secondary (symptomatic) burning mouth** driven by identifiable local and systemic factors, with a possible neuropathic/primary component and an anxiety overlay:

1. **Mucosal / infectious:** erythematous + pseudomembranous candidiasis and denture stomatitis (denture worn overnight, diabetes, xerostomia, chronic PPI) — a well-established cause of oral burning.
2. **Xerostomia:** polypharmacy with three xerostomic agents (amitriptyline, sertraline, HCTZ) plus reduced measured flow.

3. **Nutritional / metabolic:** atrophic glossitis and angular cheilitis raise concern for B12 / iron / zinc deficiency (chronic PPI + metformin + prior anemia) and glycemic contribution.
4. **Neuropathic / primary component:** evening-worse burning that eases with eating is characteristic of burning mouth; a residual primary/neuropathic component is likely once secondary causes are treated.
5. **Psychological overlay:** generalized anxiety amplifies symptom perception. No odontogenic, TMJ, neuralgic, or malignant pattern.

LD LESION / LOCAL FINDING DESCRIPTION

7 FOCAL FINDINGS

- **Candidal plaques:** multiple 2–6 mm removable white pseudomembranous plaques, posterior dorsal tongue and soft/hard palate; erythematous base on removal; non-indurated, non-fixed, non-tender to firm palpation.
- **Atrophic glossitis:** diffuse dorsal tongue erythema with papillary atrophy; no discrete ulcer or mass.
- **Angular cheilitis:** bilateral commissural erythema and fissuring.
- **Denture stomatitis:** well-demarcated erythema of the upper denture-bearing palate. Clinical photographs obtained (tongue, palate, commissures).

DR DIAGNOSTIC RESULTS

8 REVIEWED & ORDERED STUDIES

FUNGAL CULTURE / SMEAR — OBTAINED TODAY

Cytology smear from dorsal tongue plaque: budding yeast with pseudohyphae seen. Fungal culture sent (Candida albicans expected); speciation and, if recurrent, sensitivities requested.

LABORATORY STUDIES — ORDERED TODAY

CBC, ferritin/iron studies, vitamin B12, folate, zinc, HbA1c, TSH, and fasting glucose ordered through Dr. Osei. Prior labs (04/2026): borderline-low B12 254 pg/mL, ferritin 14 ng/mL (low), HbA1c 7.9%.

PRIOR DENTAL WORKUP REVIEWED

Two dental exams + periapical series (03–04/2026): no caries, cracked tooth, periapical, or periodontal source of pain.

SALIVARY ASSESSMENT

Chairside — reduced resting flow, frothy scant saliva; formal sialometry deferred pending medication review and hydration optimization.

RECORDS REQUESTED

PCP medication list, thyroid and diabetes records, and prior anemia workup reconciled today.

A ASSESSMENT

9 ORAL PAIN CLINICAL INTERPRETATION

Primary assessment: Secondary (multifactorial) burning mouth — oral burning driven by several concurrent, treatable contributors, with a probable residual primary/neuropathic component. **Confidence: HIGH for the secondary contributors.**

1. **Oral candidiasis (erythematous + pseudomembranous) and denture stomatitis** — confirmed on smear; a direct cause of burning and altered taste. Risk factors: diabetes, xerostomia, overnight denture wear, chronic PPI.
2. **Medication-induced xerostomia** — amitriptyline, sertraline, and HCTZ; reduced measured flow amplifies burning and candidal overgrowth.
3. **Suspected nutritional deficiency (iron ± B12 ± zinc)** — atrophic glossitis + angular cheilitis + low ferritin (14) and borderline B12 (254) on prior labs; chronic PPI/metformin support ongoing malabsorption.
4. **Suboptimal glycemic control** — HbA1c 7.9% predisposes to candidiasis and neuropathic burning.
5. **Primary burning mouth (neuropathic) component** — likely to persist after secondary causes are treated; will reassess.
6. **Anxiety overlay** — contributes to symptom amplification. **No red-flag or malignant features** — no indurated/non-healing ulcer, mass, fixation, or lymphadenopathy.

P PLAN

10 ORAL PAIN MANAGEMENT

1. **Antifungal therapy:** Nystatin oral suspension 100,000 U/mL, 5 mL swish-and-swallow QID × 14 days; plus **clotrimazole troches** for palate. If incomplete response, fluconazole 100 mg daily × 7–14 days (checked for interactions/QT and coordinated with Dr. Osei). **Denture hygiene:** remove nightly, soak in antifungal/chlorhexidine, brush tissue surface; reline/refit evaluation with Dr. Marchetti.
2. **Xerostomia:** Medication review with Dr. Osei — trial lowering/replacing amitriptyline and switching HCTZ to a non-xerostomic antihypertensive if feasible. Saliva substitutes, xylitol lozenges, frequent water, humidifier; avoid alcohol-based rinses.
3. **Nutritional repletion:** Repletion pending confirmatory labs — oral iron with vitamin C (ferritin 14), B12 (evaluate oral vs IM given chronic PPI), and zinc; recheck in 8–12 weeks. Coordinate PPI necessity/step-down with PCP.
4. **Glycemic optimization:** Refer back to Dr. Osei for diabetes intensification (HbA1c 7.9%).
5. **Neuropathic/primary component:** If burning persists after secondary causes treated, start **topical clonazepam** (suck-and-spit) or low-dose systemic alpha-lipoic acid / gabapentinoid; reassess at follow-up.
6. **Symptom relief & behavioral:** Bland diet, avoid spicy/acidic/carbonated triggers; capsaicin or topical strategies as adjunct. Reinforce that this is benign and manageable; anxiety/CBT support via PCP.
7. **Education:** Reviewed multifactorial nature, expected gradual improvement over weeks, denture care, and return precautions for any new non-healing ulcer, lump, or bleeding.

F FOLLOW-UP

11 REASSESSMENT PLAN

- **Oral medicine follow-up 07/16/2026 (4 weeks):** reassess burning, candidiasis clearance, xerostomia, taste, and denture fit; review nutritional labs and adjust plan.
- **Lab recheck:** ferritin, B12, zinc, and HbA1c at 8–12 weeks via Dr. Osei.
- **Escalation:** If a discrete non-healing ulcer, induration, mass, or lymphadenopathy develops, expedite for biopsy. If burning persists despite treated secondary causes, formalize primary burning-mouth neuropathic therapy.

TIME DOCUMENTATION & BILLING

TOTAL TIME
45 minutes

COUNSELING / COORDINATION TIME
22 minutes (medication review with PCP, nutritional counseling, denture-care and diet education, anxiety reassurance)

CPT / E/M CODE(S)
99204 — New patient E/M, moderate complexity; 87210 — wet-mount/smear for fungal elements

BASIS FOR BILLING
Medical Decision Making — Moderate; multiple chronic conditions, prescription management, PCP coordination, diagnostic smear/labs

PRIMARY ICD-10
K14.6 — Glossodynia (burning mouth)

SECONDARY ICD-10
B37.0 Candidal stomatitis · K13.79 Denture stomatitis · K11.7/R68.2 Xerostomia · D50.9 Iron-deficiency anemia · E11.65 T2DM w/ hyperglycemia

PROVIDER SIGN-OFF

ORAL MEDICINE SPECIALIST	CREDENTIALS	SPECIALTY	DATE	TIME
Priya Raghunathan, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine	06/18/2026	11:20 AM