Oral Health Checklist

Total Health™
BEYOND THE MOUTH

This information will assist the dental professionals in assessing both your oral health and its impact on your overall health. Please answer completely to the best of your knowledge.

Patient Name *(Last Name, First Name)* _____

Height_____ Weight_____

How frequently have you been brushing your teeth?_____

How frequently have you been flossing your teeth?_____

Do your gums bleed? ..... yes_____ no_____

Are your gums sore or swollen? ..... yes_____ no_____

Have your gums receded (do teeth look longer)?..... yes_____ no_____

Are your teeth loose?..... yes_____ no_____

Do you smoke or use tobacco products? ..... yes_____ no_____

Do you drink excessively? ..... yes_____ no_____

Do you have a persistent sore throat or ear pain?..... yes_____ no_____

Do you have unexplained numbness or pain in the face/neck/mouth?..... yes_____ no_____

Do you have a sore or lesion on the lips or mouth that has persisted for 2 weeks or more? ..... yes_____ no_____

Do you have chronic hoarseness?..... yes_____ no_____

Do you have difficulty chewing, swallowing, or moving the jaw or tongue?..... yes_____ no_____

Do you have a lump or thickening in the cheek?..... yes_____ no_____

Do you snore or have you been told in the past you snore?..... yes_____ no_____

Do you regularly have excessive daytime sleepiness?..... yes_____ no_____

Have you been diagnosed with sleep apnea? ..... yes_____ no_____

Do you have a heart condition? ..... yes_____ no_____

Is there a history of heart disease in your immediate family?..... yes_____ no_____

Do you have a family history of diabetes? ..... yes_____ no_____

Do you have high cholesterol?..... yes_____ no_____

Do you have any other health conditions? ..... yes_____ no_____

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FOR OFFICE USE ONLY

Record Blood Pressure _____

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