# Total Health

Patient Name (Last name, First name) _____

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 have unexplained numbness or pain in the face/ neck/ mouth? ..... Yes____ No____

Do you have difficult 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____

Is there a history of heart disease in your immediate family? ..... Yes____ No____

Do you have any other health conditions? ..... Yes____ No____

Are you happy with the appearance of your teeth? ..... Yes_____ No____

Are you happy with the position or alignment of your teeth? .....Yes_____ No____

If cost was not an issue is there anything you would change about your smile? ..... Yes_____ No____

If you are concerned about anything not listed above, please explain. _____

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