

Total Health Checklist

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 _____

FOR OFFICE USE ONLY

Record Blood Pressure _____

