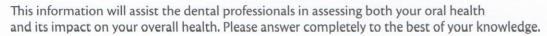
Total Health Checklist





leight	Weight	
How frequently have	you been brushing your teeth?	
How frequently have	you been flossing your teeth?	
Do your gums bleed?		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?		no
Do you drink excessively?		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?		
Do you have difficulty chewing, swallowing, or moving the jaw or tongue?yes		
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?		no
Do you have a heart condition?yes		no
Is there a history of heart disease in your immediate family?		
Do you have a family history of diabetes?		
Do you have high cholesterol?		
Do you have any oth	er health conditions?yes	no
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Record Blood Pressul	e	