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.

Total Health™
BEYOND THE MOUTH

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

Submit Form to Office

Record Blood Pressure _____

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