



Patient 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 _____

