Willows DENTAL GROUP
Impacting Lives One Smile At A Time

TOTAL HEALTH CHECKLIST

Date: _____ **Patient Name:** _____

Height: _____ **Weight:** _____

How frequently do you brush?		
How often do you floss		
	Yes	**No**
Do your gums bleed?		
Are your gums sore or swollen?		
Have your gums receded (do your teeth look “longer”)?		
Are your teeth loose?		
Do you smoke or use tobacco products?		
Do you drink excessively?		
Do you have a persistent sore throat or ear pain?		
Do you have unexplained numbness or pain in your face/neck/mouth?		
Do you have a sore or lesion on your lips or mouth that has persisted for 2 weeks or more?		
Do you have chronic hoarseness?		
Do you have difficulty chewing, swallowing, or moving your tongue or jaw?		
Do you have a lump or thickening in your cheek?		
Do you snore or have you been told in the past you snore?		
Do you have excessive daytime sleepiness?		
Have you been diagnosed with sleep apnea?		
Do you have a heart condition?		
Is there a history of heart disease, diabetes, or high cholesterol in your immediate family? (circle any that apply)		
Are you happy with your smile?		
Are you happy with the color of your teeth?		
If you could change anything about your smile or teeth what would it be?		