EXPERIENCE BIOLOGICAL DENTISTRY & ENERGY MEDICINE

SCOTT M. CHANDLER, DMD

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_____

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