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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