# DESERT MOUNTAIN OB/GYN

| *Last Name:* | *First Name:* | *D.O.B.:* |
|---|---|---|
| *Date of Examination:* | *Wt.(lbs.)* | *B.P.:* |

**Comments & Assessment Plan:**

| | | |
|---|---|---|
| 1. In the past year have you had a full dental exam? | Yes [ ] | No [ ] |
| 2. When is your next scheduled visit? | | |
| 3. Do your gums bleed when you brush or floss? | Yes [ ] | No [ ] |
| 4. Are your gums swollen or tender? | Yes [ ] | No [ ] |
| 5. Have you noticed persistent bad breath/bad taste in your mouth? | Yes [ ] | No [ ] |
| 6. Do your teeth feel loose? | Yes [ ] | No [ ] |

**IMMUNIZATION ASSESMENT**

Immunizations current? If yes, please provide immunization records.
Yes [ ] No [ ]

**REFERRALS**

[ ] Dental
[ ] Behavioral Health
[ ] CRS
[ ] Specialty

**NOTES:**