# Laser Revision New Patient Questionnaire

Patient's Name ________________________________________ Today's Date ______
Age _________ ___Male ____Female

Patient Symptoms

____Speech issues (lisp, stutter, avoiding talking, behind in speech)

____Inability to speak clearly when talking fast/loud/soft

____Food and texture aversions

____Eating issues( chewing for extended periods of time, "squirreling" food in cheeks, taking an abnormally long time to eat)

____Drinking issues (chokes/sputters, drools drink out)

____TMJ issues (pain, clicking, tension)

____Migraines

____Cavities despite excellent oral hygiene

____Pain upon toothbrushing

____Snoring

____Sleep apnea

____Acid Reflux

____Daytime sleepiness

____Behavioral issues (ADHD, hyperactivity)

____Depression

Do you have any medical conditions? ______________________________________

Do you have a bleeding disorder? ________________________________

Are you taking any medication? ___________ please list medication(s)
____________________________________________________________________

Who referred you to our office? __________________________________

Physician __________________________________ Phone number___________

Can we send a report to the physician? Yes ____ No ___ please initial _________

ENT Specialist ______________________________ Phone number___________