BREATH CARE CENTER
32910 W. 13 Mile Road
Suite C-304
Farmington Hills, MI 48334
(810) 851-8055

HALITOSIS EXAMINATION INSTRUCTIONS

Due to the nature of halitosis, it is important to obtain accurate readings at the diagnosis appointment. Please follow the instructions below so that we may make an accurate diagnosis.

Please fill out the enclosed health and information forms and return them in the enclosed envelope.

Oral Hygiene:

If your appointment is in the morning, do not brush your teeth or floss the night before or the morning of the appointment. This includes mouthwashes, sprays, gels, etc.

If your appointment is in the afternoon, do not brush your teeth or floss that day.

The day before your appointment, do not use mouthwashes, toothpastes, or any oral preparation that have an odor or a flavor.

Food:

Do no eat any food or drink any liquid for a minimum of 5 hours before your visit. The exception is water which can be taken up to 3 hours before the appointment. If you have a medical condition which precludes you from following this, please call us immediately.

No garlic, onions, cabbage, or other strong foods for 48 hours prior to your appointment.

No smoking for 12 hours prior to appointment.

No alcohol for 12 hours prior to appointment.

Please bring your prescriptions with you if you take medication.

If you are taking antibiotics for a medical condition, please notify us immediately. Your appointment must be postponed for 3 weeks after the cessation of any antibiotic therapy.

Please do not use perfume, cologne or aftershave or scented deodorants the day of your appointment.

Thank you for your adherence to these instructions. It will enable us to achieve the correct diagnosis so that we may help you eliminate your problem.

Dawn A Diesing, D.D.S.

Date:_____ Referred By:_____

PATIENT'S HISTORY AND INFORMATION

NAME:_____ BIRTH DATE:_____
RES. ADDRESS:_____ RES. PHONE:_____
BUS. ADDRESS:_____ BUS. PHONE:_____
PATIENT SS#:_____ SPOUSE SS#:_____
EMPLOYED BY:_____ OCCUPATION:_____
SPOUSE'S NAME:_____ SPOUSE'SBUS. PHONE:_____
PHYSICIAN:_____ PHYSICIAN'S PHONE:_____
PHYSICIAN'S ADDRESS:_____ SPOUSE BIRTH DATE:_____
INSURANCE COMPANY:_____

DIRECTIONS: Please answer the questions below by circling YES or NO. If any of the answers are YES, please explain in detail at the bottom.

Have you ever had a serious illness?	NO	YES
Have you ever been hospitalized or had an operation?	NO	YES
Are you HIV positive or do you have AIDS?	NO	YES
Have you ever had an unusual or allergic reaction to any drugs or medications?	NO	YES
Are you currently taking any medication?	NO	YES
Have you ever had rheumatic fever?	NO	YES
Have you had a heart attack?	NO	YES
Have you ever been told that your blood pressure was too high or too low?	NO	YES
Do you have a heart murmur (leaky valve)?	NO	YES
Do you have any sinus or respiratory problems?	NO	YES
Have you had jaundice (yellow eyes or skin)?	NO	YES
Have you ever had syphilis or any other venereal disease?	NO	YES
Do you have a problem with headaches?	NO	YES
Do you have diabetes?	NO	YES
Is there a family history of diabetes?	NO	YES
Are you frequently weak when you do not eat on schedule?	NO	YES
Do you have any illness or disease not previously mentioned?	NO	YES
Are you pregnant?	NO	YES
Have you ever had any trouble associated with previous dental treatment? (dizziness, fainting, or reaction to novocaine)	NO	YES
Do your gums ever bleed?	NO	YES
Do you notice any clicking or popping noises in your jaw?	NO	YES
Do you awaken with sore jaws or sore teeth?	NO	YES
Have you ever had severe pains of the face or head?	NO	YES
Do you ever experience bad breath?	NO	YES
Do you frequently have a bad taste in your mouth?	NO	YES
Are you satisfied with your smile?	NO	YES

Please Explain any YES Answers:_____

_____

_____

_____

When was your last dental prophylaxis (cleaning)?_____

Date:_____ Signature:_____
Recall Date:_____ Signature:_____
Recall Date:_____ Signature:_____
Recall Date:_____ Signature:_____

HALITOSIS QUESTIONNAIRE

NAME:

DATE:

Please describe your problem with halitosis.

When did it first begin?

Please describe your oral hygiene habits.

What do you currently do to help your bad breath? Please be specific.

Have you consulted any other doctors for halitosis?
If so, please list their names, addresses & phone numbers:

_____ _____
_____ _____
_____ _____

Do you take any medications? If so, please list.

_____
_____

Do you have any illnesses? If so, please give brief history.

Are you under the care of a physician? If so, please provide his or her name, address and phone number below.

_____
_____