

Name: _____ Male/Female DOB: / / Pin #: _____

Level of erosion: slight moderate advanced

Pics taken: yes no Study models Y N

1. Do you eat close to bedtime?
2. High fat diet?
3. Does your mouth feel dry? Cottonmouth?
4. Trouble eating dry foods?
5. Difficulty swallowing?
6. Do you feel the need to sip liquids often?
7. What medications do you use? Tums? Antihistamines?
8. Asthma?
9. Smoking?
10. Drinking?
11. Parents or siblings have reflux?
12. Heartburn?
13. Sense of lump in throat?
14. Sore throat?
15. Hoarseness of voice?
16. Voice change?
17. Excess salivation?
18. Gastric pain on awakening?
19. Halitosis?
20. Bronchitis? Laryngitis?
21. Acidic beverages? Coffee, beer, wine, citrus juices, sodas?
22. How long have symptoms been present? Prediagnosed GERD? Referred?
23. Do you frequently regurgitate your food?

Proposed Tx- Referral?

Fluoride trays?

Cut back on extrinsic sources?

Results of referral: