# Patient Health Questionnaire

TM

**PATIENT Information** **Date of completion**______

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

**Name**: ______________________________________________

First Middle Initial Last

Age: ______________ Date of Birth: _______________

**Referred by:** ______________________________ ☐DDS ☐MD ☐ENT ☐DC ☐Other

Location and/or Phone Number of Referring Dr: ______________________________

Patient Address: __________________________ City: _________________ State: _________ Zip: _______

Home Phone: _________________________ Alternate Contact Number: ___________________________

Type of Employment: ____________________________________________

Responsible Party (if different than Patient): ______________________________

Address: ______________________________ City: _________________ State: _________ Zip: _______

Family Dentist: _________________________ Address and/or Phone: ______________________________

Family Physician: _________________________ Address and/or Phone: ______________________________

**Reason(s) for this appointment**: ____ Pain ____ Sleep/Airway ____ Orthodontics ____ Unknown

**WHAT IS THE CHIEF COMPLAINT FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?**

**NOTE-PLEASE IDENTIFY YOUR CHIEF COMPLAINT AS #1, LIST ALL OTHER SYMPTOMS IN PRIORITY #2-9.**

| Symptom | Recent | Chronic (6 mo.+) | Symptom | Recent | Chronic (6 mo.+) |
|---|---|---|---|---|---|
| ___ Headache pain | ☐ | ☐ | | ☐ | ☐ |
| ___ Ear pain | ☐ | ☐ | ___ Kicking or jerking leg repeatedly | ☐ | ☐ |
| ___ Jaw pain | ☐ | ☐ | ___ Swelling in ankles or feet | ☐ | ☐ |
| ___ Pain when chewing | ☐ | ☐ | ___ Morning Hoarseness | ☐ | ☐ |
| ___ Facial pain | ☐ | ☐ | ___ Dry mouth upon waking | ☐ | ☐ |
| ___ Eye pain | ☐ | ☐ | ___ Fatigue | ☐ | ☐ |
| ___ Throat pain | ☐ | ☐ | ___ Difficulty falling asleep | ☐ | ☐ |
| ___ Neck pain | ☐ | ☐ | ___ Tossing and turning frequently | ☐ | ☐ |
| ___ Shoulder pain | ☐ | ☐ | ___ Repeated awakening | ☐ | ☐ |
| ___ Back pain | ☐ | ☐ | ___ Feeling unrefreshed in the morning | ☐ | ☐ |
| ___ Limited ability to open mouth | ☐ | ☐ | ___ Significant daytime drowsiness | ☐ | ☐ |
| ___ Jaw joint locking | ☐ | ☐ | ___ Frequent heavy snoring | ☐ | ☐ |
| ___ Jaw joint noises | ☐ | ☐ | ___ Affects sleep of others | ☐ | ☐ |
| ___ Ear congestion | ☐ | ☐ | ___ Gasping when waking | ☐ | ☐ |
| ___ Sinus congestion | ☐ | ☐ | ___ Told that "I stop breathing" during sleep | ☐ | ☐ |
| ___ Dizziness | ☐ | ☐ | ___ Night-time choking spells | ☐ | ☐ |
| ___ Tinnitus (ringing in the ears) | ☐ | ☐ | ___ Unable to tolerate C-Pap | ☐ | ☐ |
| ___ Muscle twitching | ☐ | ☐ | ___ Tooth grinding | ☐ | ☐ |
| ___ Vision problems | ☐ | ☐ | ___ Teeth crowding | ☐ | ☐ |

Other: ____________________________________________

Do you have concerns in any of these areas: ___ General Appearance ___ Overbite
___ Ability to Function ___ Smile

Other Comments: ____________________________________________

____________________________________________

**Do any of the above complaints or concerns affect your daily life?** ______________________

## WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT?

____________________________________________

Patient Signature: ______________________________ Date: ______________________

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## ALLERGIC REACTIONS

*Please check any and all medications or substances that have caused an allergic reaction*

| | | |
|---|---|---|
| ☐ Anesthetics | ☐ Codeine | ☐ Penicillin |
| ☐ Antibiotics | ☐ Iodine | ☐ Plastic |
| ☐ Aspirin | ☐ Latex | ☐ Sedatives |
| ☐ Barbituates | ☐ Metals | ☐ Sulfa |

Other: ______________________________________________________________________

## CURRENT MEDICATIONS

*Please list all medications you are taking and the reason you take them. Include all over-the-conter medications, vitamins, herbs, etc.*

| Medication | Dosage | Reason for Taking |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

| Treatment and/or Medication | Doctor/Provider Name | Approximate Date of Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

______________________________________________________________________

______________________________________________________________________

**I release and give my permission for this office to request information and communicate with the providers listed above.**

**Patient Signature:** ______________________________ **Date:** ___________________________

**Parent/Guardian Signature (if patient is a minor):** ______________________________ **Date:** _____________

## HEALTH AND MEDICAL HISTORY

☐Yes ☐No Are you currently pregnant?

☐Yes ☐No Have you sustained injury to: ☐Head ☐Neck ☐Face ☐Teeth ☐Other _______________

☐Yes ☐No Do you drink 4 or more cups of coffee per day? ☐Yes ☐No Do you smoke tobacco?

☐Yes ☐No Have you had prior orthodontic treatments. ☐Yes ☐No Consume alcohol or take sedatives

☐Yes ☐No Trouble breathing through nose

Patient Signature: ___________________________________________ Date: ________________________

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## HEALTH AND MEDICAL HISTORY (CONTINUED)

*Do you have, or have you experienced any of the following:*

☐Yes ☐No Heart Disorder/ Heart Attack
☐Yes ☐No Heart Murmur
☐Yes ☐No Mitral Valve prolaps
☐Yes ☐No Heart Pacemaker
☐Yes ☐No Heart Palpitations
☐Yes ☐No Heart Valve Replacement
☐Yes ☐No Irregular Heartbeat
☐Yes ☐No Blood Pressure ___ High ___ Low
☐Yes ☐No Stroke
☐Yes ☐No Bleeding Easily
☐Yes ☐No Bruising Easily
☐Yes ☐No Cancer of ___________________
☐Yes ☐No Chemo ______ Radiation _____
☐Yes ☐No Anemia
☐Yes ☐No Asthma
☐Yes ☐No Birth Defects
☐Yes ☐No Diabetes
☐Yes ☐No Epilepsy
☐Yes ☐No Emphysema
☐Yes ☐No Glaucoma
☐Yes ☐No Gastroesophpgeal Reflex (Gerd)
☐Yes ☐No Hemophilia
☐Yes ☐No Hepatitis
☐Yes ☐No History of Substance Abuse
☐Yes ☐No Hypoglycemia
☐Yes ☐No Huntington's Disease
☐Yes ☐No Kidney Disease
☐Yes ☐No Liver Disease
☐Yes ☐No Leukemia
☐Yes ☐No Migraines
☐Yes ☐No Meniere's Disease
☐Yes ☐No Multiple Sclerosis
☐Yes ☐No Muscular Dystrophy
☐Yes ☐No Neuralgia
☐Yes ☐No Osteoarthirtis
☐Yes ☐No Osteoporosis
☐Yes ☐No Overian Cysts
☐Yes ☐No Parkinson's Disease
☐Yes ☐No Rhuematic Fever
☐Yes ☐No Rhuematoid Arthritis
☐Yes ☐No Scarlet Fever

☐Yes ☐No Thyroid Problem
☐Yes ☐No Tuberculosis
☐Yes ☐No Intestinal Disorder
☐Yes ☐No Nervous System Disorder
☐Yes ☐No Anxiety
☐Yes ☐No Skin Disorder
☐Yes ☐No Urinary Tract Disorder
☐Yes ☐No Chronic Fatigue
☐Yes ☐No Fibromyalgia
☐Yes ☐No Cold hands and feet
☐Yes ☐No Depression
☐Yes ☐No Difficulty concentrating
☐Yes ☐No Difficulty breathing at night for sleep
☐Yes ☐No Dizziness
☐Yes ☐No Excessive Thirst
☐Yes ☐No Fainting
☐Yes ☐No Fluid Retention
☐Yes ☐No Frequent colds/flu
☐Yes ☐No Frequent cough
☐Yes ☐No Frequent ear infections
☐Yes ☐No Frequent sore throat
☐Yes ☐No Frequent awaking at night - number of times _____
☐Yes ☐No Hearing impairment
☐Yes ☐No Memory Loss
☐Yes ☐No Hay Fever
☐Yes ☐No Insomnia
☐Yes ☐No Muscle aches
☐Yes ☐No Muscle fatigue
☐Yes ☐No Muscle spasms
☐Yes ☐No Muscle tremors
☐Yes ☐No Poor circulation
☐Yes ☐No Psychiatric Care
☐Yes ☐No Recent weight gain
☐Yes ☐No Recent weight loss
☐Yes ☐No Sinus problems
☐Yes ☐No Shortness of breath
☐Yes ☐No Slow healing sores
☐Yes ☐No Speech difficulties
☐Yes ☐No Swollen, stiff or painful joints
☐Yes ☐No Tired muscles

Additional Information ______________________________________________________________________
______________________________________________________________________________

## SURGICAL HISTORY *Have you had any of the following:*

☐Yes ☐No General Anesthesia
☐Yes ☐No Adnoids removed
☐Yes ☐No Tonsils removed
☐Yes ☐No Jaw Joint Surgery

☐Yes ☐No Orthognathic Surgery
☐Yes ☐No Oral Surgery
Removal of third molar (wisdom teeth) _____ Other _____
☐Yes ☐No Other surgery ________________________
*please list below*

Other types of surgery ______________________________________________________

Patient Signature: ____________________________ Date: ____________________

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## CURRENT SYMPTOMS

### Head Pain

| ***Location*** <br> *L=Left R=Right B=Bilateral* | *Recent* | *Chronic* <br> *(over 6 mo.)* | *Severity* <br> *Mild* | <br> *Mod* | <br> *Severe* | *Duration* <br> *Min.* | <br> *Hrs.* | <br> *Days* | *Frequency* <br> *Occasional* | <br> *Frequent* | <br> *Constant* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| L R B Frontal (Forehead) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B Generalized | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B Parietal (Top of head) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B Occipital (Back of head) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L R B Temporal (Temple area) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*Do you have pain or discomfort in any of the following areas? If so, please indicate the approximate date the pain began.*

### Jaw Pain

☐L ☐R Jaw pain with opening
☐L ☐R Jaw pain when chewing
☐L ☐R Jaw pain at rest

### Jaw Joint Sounds

☐L ☐R Jaw sounds with opening
☐L ☐R Jaw sounds when chewing
☐L ☐R Jaw sounds at rest

### Jaw Locking

☐Yes ☐No Jaw locks closed
☐Yes ☐No Jaw locks open
☐Yes ☐No Joint noises

### Jaw Joint Symptoms

☐Yes ☐No Teeth clenching
☐Yes ☐No Teeth grinding

### Eye Related Conditions

☐Yes ☐No Blurred vision
☐Yes ☐No Double vision
☐Yes ☐No Eye pain
☐Yes ☐No Pain or pressure behind the eyes
☐Yes ☐No Extreme sensitivity to light (photophobia)
☐Yes ☐No Wear of glasses or contact lenses

### Ear Related Conditions

☐L ☐R Buzzing in the ears
☐L ☐R Ear congestion
☐L ☐R Ear pain
☐L ☐R Hearing loss
☐Yes ☐No Itchiness or Stuffiness in ears
☐L ☐R Pain behind the ear
☐L ☐R Pain in front of the ear
☐L ☐R Recurrent ear infections
☐L ☐R Ringing in the ear (Tinnitus)

### Throat Related Conditions

☐Yes ☐No Chronic sore throat
☐Yes ☐No Difficulty swallowing
☐Yes ☐No Swollen glands
☐Yes ☐No Thyroid enlargement
☐Yes ☐No Tightness in throat
☐Yes ☐No Constant feeling of a foreign object in throat

### Neck Related Conditions

☐Yes ☐No Limited movement of neck
☐Yes ☐No Neck pain
☐Yes ☐No Numbness in hands or fingers
☐Yes ☐No Swelling in the neck

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### Shoulder Related Conditions

☐Yes ☐No Shoulder pain
☐Yes ☐No Shoulder stiffness
☐Yes ☐No Tingling in hands or fingers

### Back Related Conditions

☐Yes ☐No Back pain - lower
☐Yes ☐No Back pain - middle
☐Yes ☐No Back pain - upper
☐Yes ☐No Sciatica
☐Yes ☐No Scoliosis

### Mouth and Nose Related Conditions

☐Yes ☐No Dry mouth
☐Yes ☐No Chronic sinusitis
☐Yes ☐No Frequent snoring
☐Yes ☐No Burning tongue
☐Yes ☐No Broken teeth
☐Yes ☐No Frequent biting of the cheek

### Sleep Conditions

Sleep Positions ☐ Side ☐ Back ☐ Stomach
Is it easy to fall asleep? _______
Do you feel rested upon AM waking? ______
Stopped breathing during sleep?______
Average hours of sleep per night?______
Do you wake often during the night? ______
Gasping or Choking during sleep?____
Have you ever had a Sleep Study (PSG)?____

## HISTORY OF SYMPTOMS

On what date, or approximate date, did this condition or symptoms first occur? ____________________________
☐Yes ☐No Does any family member have the same or similar problem? If yes, please explain. ___________________
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? ________________________

**If yes, please complete Trauma History Section, enclosed as a separate form.**

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient Signature: ___________________________________________ Date: ________________________

Parent/Guardian Signature (if patient is a minor): ______________________________ Date: _____________

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