Patient Health Questionnaire

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

Name: _____
First Middle Initial Last

Date of Birth: _____ **Age:** _____ **Referred By:** _____

Patient Address: _____ **City:** _____ **Prov:** _____ **Postal:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Responsible Party (if different than patient): _____

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.

	Recent	Chronic
____Headache pain	☐	☐
____ Jaw pain	☐	☐
____Pain when chewing	☐	☐
____Jaw joint locking	☐	☐
____Jaw joint noises	☐	☐
____Limited ability to open mouth	☐	☐
____Eye pain	☐	☐
____Ear pain	☐	☐
____Ear congestion	☐	☐
____Tinnitus (Ringing in the ears)	☐	☐
____Sinus congestion	☐	☐
____Dizziness	☐	☐
____Throat pain	☐	☐
____Neck pain	☐	☐
____Shoulder pain	☐	☐
____Back pain	☐	☐
____Muscle twitching	☐	☐
____Vision problems	☐	☐

	Recent	Chronic_
____Teeth clenching/grinding	☐	☐
____Teeth crowding	☐	☐
____Difficulty falling asleep	☐	☐
____Repeated awakening	☐	☐
____Tossing/turning frequently	☐	☐
____Frequent heavy snoring	☐	☐
____Affects sleep of others	☐	☐
____Told 'I stop breathing' during sleep	☐	☐
____choking spells	☐	☐
____Gasping when waking	☐	☐
____Dry mouth upon waking	☐	☐
____Morning hoarseness	☐	☐
____Feeling unrefreshed in the morning	☐	☐
____Significant daytime sleepiness	☐	☐
____Fatigue	☐	☐
____Swelling in ankles or feet	☐	☐
____Kicking or jerking leg repeatedly	☐	☐
____Other: _____	☐	☐

Do you have concerns in any of these areas: ☐General Appearance ☐Ability to Function ☐Overbite ☐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:** _____

ALLERGIC REACTIONS *(Please check any and all medications or substances that have caused an allergic reaction)*

☐ Anesthetics	☐ Antibiotics: _____	☐ Aspirin
☐ Barbiturates	☐ Codeine	☐ Iodine
☐ Latex	☐ Metals	☐ Sulfa
☐ Plastics	☐ Sedatives	☐ Other: _____

CURRENT MEDICATIONS *(Please list all medications including over-the-counter medications, vitamins, herbs, etc)*

Medication	Dosage	Reason

☐ See attached list

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment(s)

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 Consume alcohol or sedatives

DENTAL HISTORY

☐ Yes ☐ No Previous orthodontic treatment (Braces, Invisalign, etc)?
☐ Yes ☐ No Oral surgery (tooth extractions, etc)?
☐ Yes ☐ No Orthognathic surgery?
☐ Yes ☐ No Jaw joint surgery?

Patient Signature: _____ **Date:** _____

HEALTH AND MEDICAL HISTORY (CONTINUED)

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

- ☐ Heart Disorder / Heart attack
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart Pacemaker
- ☐ Heart Palpitations
- ☐ Heart Valve Replacement
- ☐ Irregular heartbeat
- ☐ Blood pressure High / Low
- ☐ Stroke
- ☐ Bleeding easily
- ☐ Bruising easily
- ☐ Cancer: _____
- ☐ Anemia
- ☐ Asthma
- ☐ Birth Defects
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Gastroesophageal Reflex
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ History of substance abuse
- ☐ Hypoglycemia
- ☐ Huntington's Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Migraines
- ☐ Meniere's Disease
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuralgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Ovarian Cyst
- ☐ Parkinson's Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Intestinal Disorder
- ☐ Nervous System Disorder
- ☐ Anxiety
- ☐ Skin Disorder
- ☐ Urinary Tract Disorder
- ☐ Chronic fatigue
- ☐ Fibromyalgia
- ☐ Cold hands and feet
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Difficulty breathing during sleep
- ☐ Dizziness
- ☐ Excessive thirst
- ☐ Fainting
- ☐ Fluid retention
- ☐ Frequent colds/flu/cough
- ☐ Frequent ear infections
- ☐ Frequent sore throat
- ☐ Frequent waking at night
- ☐ Hearing impairment
- ☐ Memory loss
- ☐ Hay fever
- ☐ Insomnia
- ☐ Muscle aches
- ☐ Muscle fatigue
- ☐ Muscle spasms
- ☐ Muscle tremors
- ☐ Poor circulation
- ☐ Psychiatric care
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Sinus problems
- ☐ Shortness of breath
- ☐ Slow healing sores
- ☐ Speech difficulties
- ☐ Swollen/stiff/painful joints
- ☐ Tired muscles
- ☐ Other: _____

SURGICAL HISTORY

- ☐ Yes ☐ No General Anesthesia
- ☐ Yes ☐ No Adenoids Removed
- ☐ Yes ☐ No Tonsils Removed

Other surgeries: _____

Patient Signature: _____ **Date:** _____

CURRENT SYMPTOMS

Head Pain

Location *l =l efl R=Right B=Bilate ral*	*Recent*	*Chronic* *(over 6 mo.)*	*Severity* *Mild Mod Severe*	*Duration* *Min. Hrs. Days*	*Frequency* *Occasional Frequent Constant*
L R B Frontal (Forehead)					
L R B Generalized					
L R B Parietal (Top of head)					
L R B Temporal (Temples)					
L R B Occipital (Back of head)					

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

Oral habits

Yes No Teeth clenching Day Night
Yes No Teeth grinding Day Night

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
Yes No Wear of glasses or contact lenses

Ear Related Conditions

L R Ear pain
L R Pain in front of ear
L R Pain behind of ear
L R Ear congestion
L R Hearing loss
L R Buzzing in the ears
L R Ringing in the ears
L R Recurrent ear infections
L R Itchiness or stuffiness in ears

Nose Related Conditions

Yes No Nasal / Sinus Congestion
Yes No Trouble breathing through nose
Yes No Chronic sinusitis
Yes No Deviated nasal septum

Mouth Related Conditions

Yes No Dry mouth
Yes No Frequent biting of cheeks
Yes No Burning mouth/tongue
Yes No Broken/chipped teeth

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 object in throat

Neck Related Conditions

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

Patient Signature: _____ **Date:** _____

Shoulder Related Conditions

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

Back Related Conditions

☐ Yes ☐ No Upper back pain
☐ Yes ☐ No Middle back pain
☐ Yes ☐ No Lower back pain
☐ Yes ☐ No Sciatica
☐ Yes ☐ No Scoliosis

Sleep Related Conditions

Sleep positions ☐ Side ☐ Back ☐ Stomach

☐ Yes ☐ No Easy to fall asleep?
☐ Yes ☐ No Wake up often?
☐ Yes ☐ No Wake up rested?

Average hours of sleep per night: _____

☐ Yes ☐ No Frequent snoring
☐ Yes ☐ No Gasping/choking during sleep
☐ Yes ☐ No Ever had a sleep study?
Result: _____

HISTORY OF SYMPTOMS

On what date, or approximate date, did this condition or symptom(s) first occur? _____

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____

Does any of your family members have the same or similar condition? _____

AUTHORIZATION TO RELEASE

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

Release assessment report to:

Doctor's name	Location	Phone

Patient Signature: _____ **Date:** _____

DRAW YOUR PAIN PATTERNS FOLLOWING THIS KEY:

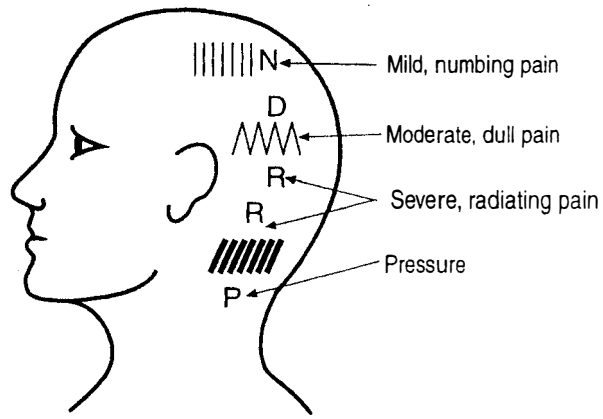
MILD PAIN |||||||

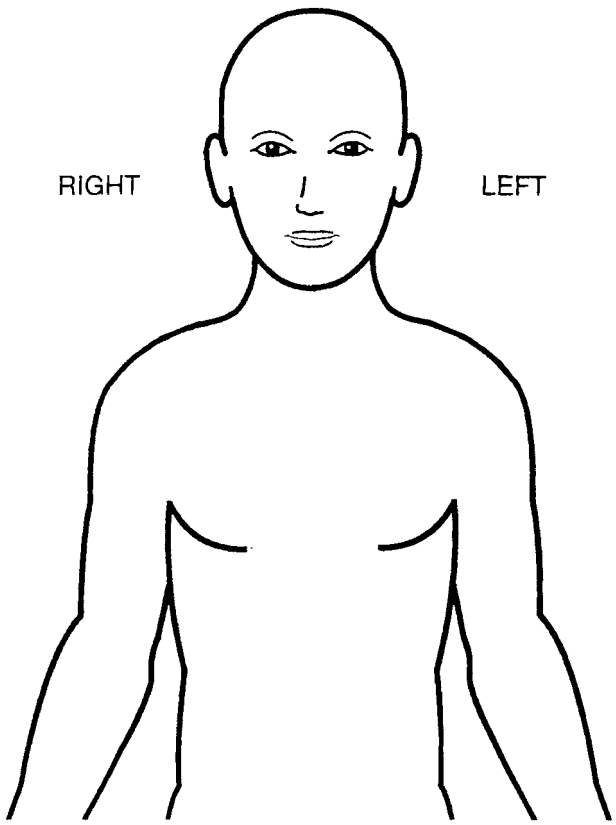
MODERATE PAIN /\/\/\

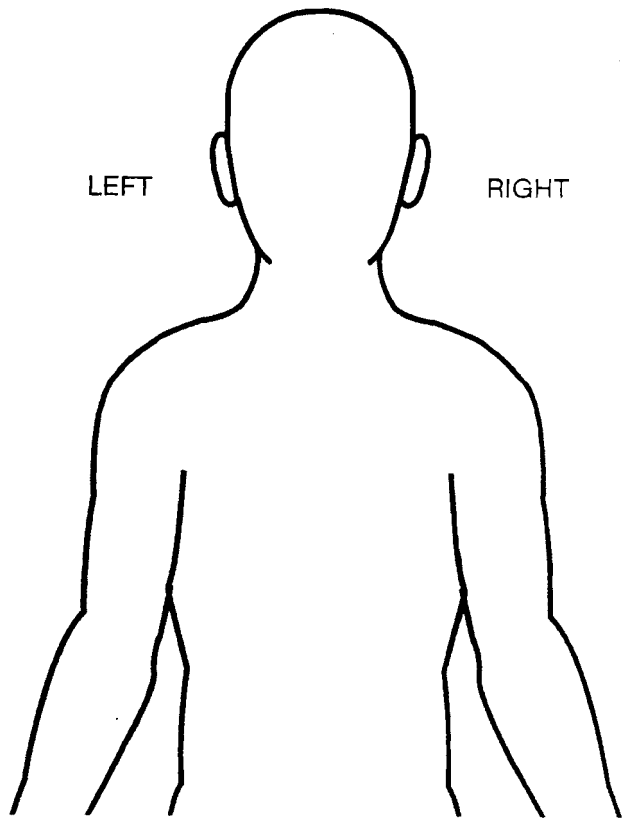
SEVERE PAIN ////////

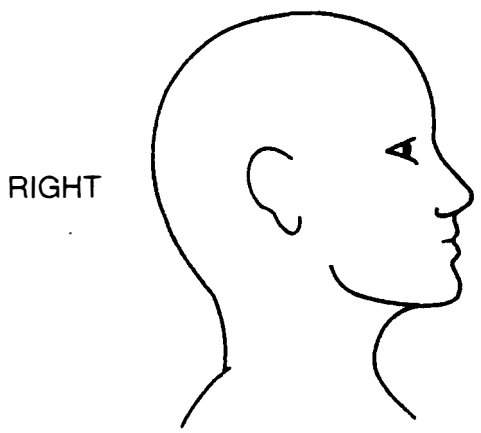
B Burning
D Dull
N Numbing
P Pressure
S Sharp
T Tingling
R Radiating

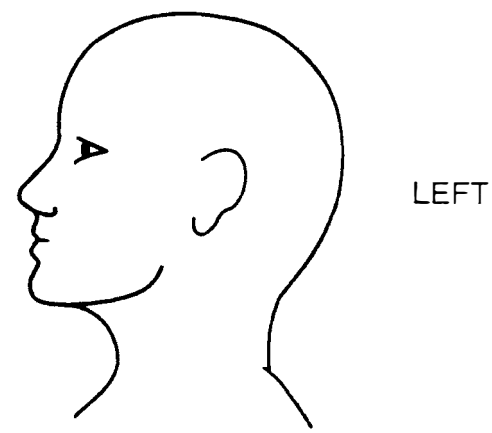
EXAMPLE:











Patient Signature _____ Date _____

Daytime Sleepiness Evaluation

Epworth Sleepiness Scale

The Epworth Sleepiness Scale was developed and validated by Dr. Murray Johns of Melbourne Australia. It is a simple, self-administered questionnaire -widely used by sleep professionals in quantifying the level of daytime sleepiness.

For the following situations, answer with one of the following numbers:

0 - Would never doze

1 - slight chance of dozing

2 - moderate chance of dozing

3 - high chance of dozing

Situation	**Score**
Sitting and reading	
Watching Television	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

Date: _____

Nighttime Sleepiness Evaluation

Screening Tool for Sleep Apnea

Developed by David White, MD., Harvard Medical School, Boston, MA

Please answer the following questions.

1.Snoring

a) Do you snore on most night (> 3 nights per week)?

Yes (2) No (0) _____

b) Is your snoring loud? Can it be heard through a door or wall?

Yes (2) No (0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) _____

3. What is your collar size?

Male: Less than 17 inches (0) more than 17 inches (5) _____

Female: Less than 16 inches (0) more than 16 inches (5) _____

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes (2) No (0) _____

b) You are driving or stopped at a light?

Yes (2) No (0) _____

5. Have you had or are you being treated for high blood pressure?

Yes (1) No (0) _____

TOTAL _____

Score

9 points or more	**6-8 points**	**5 points or less**
Refer to sleep specialist or order sleep study	Gray area, use clinical judgment	Low probability of sleep apnea

Date: _____

Vancouver TMJ &
Sleep Therapy Centre

PHQ-9

Patient Name:_____ Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Vancouver TMJ
& Sleep Therapy Centre

GAD-7 ANXIETY

Date: _____

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

SCORING GAD-7 ANXIETY SEVERITY

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4:	minimal anxiety
5–9:	mild anxiety
10–14:	moderate anxiety
15–21:	severe anxiety

Trauma History

Patient Name: _____ Date: _____

Patient Address: _____ City: _____ Prov: _____ Postal: _____
Home Phone: _____ Alternate Contact Number: _____

If any of the following traumatic events are currently under litigation, please answer questions with asterisks (*).

Beginning with the most recent accident, describe each accident by date and answer the questions in each section.

MVA (Motor Vehicle Accident)
Supply Contact Information for Attorney

Date: _____ Time of accident: _____
Was this accident work related? Yes ☐ No ☐ Were you the driver? Yes ☐ No ☐
I was a passenger seated in the: front bench seat ☐; front bucket seat ☐; rear drivers side seat ☐; rear passenger side seat ☐
The vehicle I was in at the time of the accident was a _____ (car, truck, SUV, etc.)
The vehicle I was riding in collided with: _____. (Describe the type of vehicle or structure.)
Please describe the accident: _____
_____
_____
* Location of where the vehicle you were riding in was hit/struck: (Describe) _____
_____
* Was your vehicle stopped _____ or moving _____? If moving, what speed _____mph?
* If known, what was the speed of the vehicle that stuck the vehicle you were riding in _____mph?
* Did your head forcibly strike any structure? (Example: side window, steering wheel, headrest, etc.) Describe: _____
_____
* Did any other body part forcibly strike any structure? (Example: knees, elbows, etc.) Describe: _____
_____
*Did you lose consciousness? Yes ☐ No ☐ * What body parts were painful after the accident? Describe: _____
_____
* What other symptoms were present after the accident: Describe: _____
_____
* Were you taken to the hospital by ambulance? Yes ☐ No ☐ * What hospital were you taken to? _____
* If you were not taken to a hospital by ambulance, when did you first seek treatment for your injuries? Describe: _____
_____
* Do you or your attorney have a copy of the accident report? Yes ☐ No ☐ Not sure ☐
* Attorney name _____ * Phone # _____
*Attorney Address: _____

Second MVA (Motor Vehicle Accident)
Supply Contact Information for Attorney

Date: _____ Time of accident: _____
Was this accident work related? Yes ☐ No ☐ Were you the driver? Yes ☐ No ☐
I was a passenger seated in the: front bench seat ☐; front bucket seat ☐; rear drivers side seat ☐; rear passenger side seat ☐
The vehicle I was in at the time of the accident was a _____ (car, truck, SUV, etc.)
The vehicle I was riding in collided with: _____. (Describe the type of vehicle or structure.)
Please describe the accident: _____
_____
_____
* Location of where the vehicle you were riding in was hit/struck: (Describe) _____

* Was your vehicle stopped ☐ or moving ☐? If moving, what speed _____mph?

* If known, what was the speed of the vehicle that stuck the vehicle you were riding in _____mph?

* Did your head forcibly strike any structure? (Example: side window, steering wheel, headrest, etc.) Describe:_____

* Did any other body part forcibly strike any structure? (Example: knees, elbows, etc.) Describe: _____

* Did you lose consciousness? Yes ☐ No ☐ * What body parts were painful after the accident? Describe: _____

* What other symptoms were present after the accident: Describe: _____

* Were you taken to the hospital by ambulance? Yes ☐ No ☐ * What hospital were you taken to? _____

* If you were not taken to a hospital by ambulance, when did you first seek treatment for your injuries? Describe:_____

* Do you or your attorney have a copy of the accident report? Yes ☐ No ☐ Not sure ☐

* Attorney name _____ * Phone # _____

* Attorney Address:_____

Other Trauma

List in order of most recent

Date: _____ Time of accident: _____

Was this a work related injury? Yes ☐ No ☐

Describe the location and how the injury occurred:_____

Date: _____ Time of accident: _____

Was this a work related injury? Yes ☐ No ☐

Describe the location and how the injury occurred:_____

Additional Trauma

List in order of most recent

Date: _____ Time of accident: _____

Was this a work related injury? Yes ☐ No ☐

Describe the location and how the injury occurred: _____

Date: _____ Time of accident: _____

Was this a work related injury? Yes ☐ No ☐

Describe the location and how the injury occurred: _____

VANCOUVER TMJ & SLEEP THERAPY CENTRE

To protect you, our other patients, and our care team at the Centre,
we are committed to take extreme precaution/care to prevent this virus from spreading.

CONSENT TO TREATMENT FORM*

Please read and fill out this form in a timely manner, otherwise your treatment appointment could be delayed.

The novel coronavirus SARS-CoV-2 causes the disease known as COVID-19. It has become a world-wide Pandemic. I understand that this coronavirus has an incubation period during which some of the carriers of this virus may not show symptoms, but they could still be contagious.

I understand that during my travel to the TMJ Therapy Centre for this dental visit, I could be unknowingly exposing myself to this coronavirus that were left on surfaces such as door handles, elevator buttons and from aerosols from anyone passing by. During this contact, transmission of this coronavirus is potentially possible. _____(Initial)

I understand that due to the frequency of visits by other patients, the characteristics of this coronavirus, and from having dental procedures, I have an elevated risk of contracting this coronavirus simply by being in any enclosed office. _____(Initial)

At times, aerosol-generating procedures will be required and performed in the Centre. The ultra-fine nature of the aerosol spray can linger in the air for minutes to sometimes hours, which could transmit the novel coronavirus.

I confirm that I am seeking TMD, OSA or Orthodontic treatment at the Vancouver TMJ & Sleep Therapy Centre during the Covid 19 Pandemic with the full knowledge of possible potential risk of contracting this virus. _____(Initial)

We kindly ask you to make declaration of the following:

I confirm that I am not currently positive for the novel coronavirus. _____(Initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. _____(Initial)

I verify that I have not returned to British Columbia from any country outside of Canada whether by car, air, bus or train in the past 14 days. _____(Initial)

I understand that any travel from any country outside of Canada, including travel by car, air, bus or train, could significantly increase my risk of contracting and transmitting the novel coronavirus. BC's Provincial Health Officer requires self-isolation for 14 days from the date a person has returned to Canada. _____(Initial)

I understand that BC's Provincial Health Officer has asked individuals to maintain social distancing of at least 2 metres (6 feet). However, it is not possible to maintain this distance and receive dental treatment. _____(Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or have been asked to self-isolate by BC's Provincial Health Officer, the Communicable Disease Control or any other governmental health agency. _____(Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19:

Flu-like symptoms	_____	(Initial)
Fever > 37.5 C	_____	(Initial)
Cough	_____	(Initial)
Sore Throat.	_____	(Initial)
Shortness of Breath	_____	(Initial)

I confirm that I will not attend any future appointments, if I experience any flu-like symptoms , have been in contact with a positive Covid-19 case, test positive for Covid-19 myself, or am awaiting Covid-19 test results: _____ (Initial)

To protect you, our staff and doctors have gone through this same declaration and are using Personal Protection Equipment (PPE) to prevent contracting virus from the working place. Please read the following Pandemic Protection Plan we are using to protect everyone while receiving care from us.

- Please complete & return our questionnaires by email or fax so that we can print them out using the office paper.
- We have adopted changes to facilitate social distancing amongst ourselves within the workplace. Please also do the same in the office with most staff and all patients (our appointments are not staggered like before to help minimize cross-patient interactions).
- We increase hand washing/disinfection requirement to you and to all team members
- We remove all unnecessary items within all patient area to facilitate cleaning and disinfection
- We schedule appointments to have no more than two patients within the office space in any moment
- Please wear facial covering / mask at all times to get to our office and keep your facial covering on, unless we ask you to remove it during any part of your dental treatment.
- Our office will text you to remain in the safety of your vehicle when you arrive. Once you are parked, please reply with a text to sign in. The office will update you when you can enter the office.
- If anyone is traveling with you, it is best for this person to stay outside of the office, in the lobby, hallway or in your car. However, if you need assistance to get to our office, the reception room would have a chair for this person. Movement of this person will be restricted to the waiting room and we need this person to please wear facial covering as well. Only one parent/guardian can accompany an underage patient.
- Upon arriving at our office, please wait outside the door. Our receptionist will take your temperature prior to entering. Anyone with temperature higher than 38 degree Celsius will be sent home (our apologies in advance).
- Hand washing or the use of hand sanitizer will be required immediately upon your arrival inside the office.
- A 10% hydrogen peroxide will be used for soaking your oral appliances and for mouth rinsing for 60 seconds to kill any potential virus before we examine you.
- Please wash your hands or use a hand sanitizer before you leave the treatment room area and before you leave our office.
- Please talk to our reception staff at least one foot away from the reception area shield

Name: _____ Date:_____

Signature:_____

*This consent form is conforming the recommendations of the CDSBC (College of Dental Surgeons of BC).