

Patient Health Questionnaire



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 Healthcare Provider: _____

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.

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

ALLERGIC REACTIONS

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

- Anesthetics
- Antibiotics
- Aspirin
- Barbituates

- Codeine
- Iodine
- Latex
- Metals

- Penicillin
- Plastic
- Sedatives
- Sulfa

Other: _____

CURRENT MEDICATIONS

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

Medication	Dosage	Reason for Taking

See attached list

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 Have you had prior orthodontic treatments?
- Yes No Trouble breathing through nose
- Yes No Do you smoke tobacco?
- Yes No Consume alcohol or take sedatives

Patient Signature: _____

Date: _____

HEALTH AND MEDICAL HISTORY (CONTINUED)

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disorder/ Heart Attack
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve prolaps
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Pacemaker
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Palpitations
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Valve Replacement
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irregular Heartbeat
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding Easily
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bruising Easily
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer of
		Chemo <input type="checkbox"/> Radiation <input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Birth Defects
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastroesophgeal Reflex (Gerd)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemophilia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of Substance Abuse
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypoglycemia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Huntington's Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leukemia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meniere's Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscular Dystrophy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuralgia
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoarthritis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ovarian Cyst
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever

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

Additional Information _____

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	General Anesthesia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthognathic Surgery
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Adenoids removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Oral Surgery
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsils removed	Removal of third molar (wisdom teeth) <input type="checkbox"/> Other <input type="checkbox"/>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Jaw Joint Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other surgery _____

please list below

Other types of surgery _____

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS

Head Pain

<i>Location</i>			<i>Recent</i>	<i>Chronic</i> <i>(over 6 mo.)</i>	<i>Severity</i>			<i>Duration</i>			<i>Frequency</i>		
<i>L=Left R=Right B=Bilateral</i>					<i>Mild</i>	<i>Mod</i>	<i>Severe</i>	<i>Min.</i>	<i>Hrs.</i>	<i>Days</i>	<i>Occasional</i>	<i>Frequent</i>	<i>Constant</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frontal (Forehead)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Generalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parietal (Top of head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occipital (Back of head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Temporal (Temple area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Jaw Joint Symptoms

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 (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
 L R Itchiness or Stiffness 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

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 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

Please select Yes or No answers based on your average sleep experience and/or what a sleep partner has told you

Sleep Positions Side Back Stomach Varies

Average hours of sleep per night? _____

Is it easy to fall asleep? Yes No

Do you wake often during the night? Yes No

Do you feel rested upon AM waking? Yes No

Gaspings or Choking during sleep? Yes No

Stopped breathing during sleep? Yes No

Have you ever had a Sleep Study (PSG)? Yes No

Result was _____

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. _____

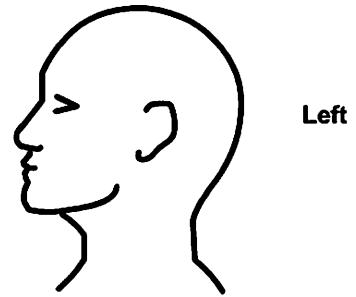
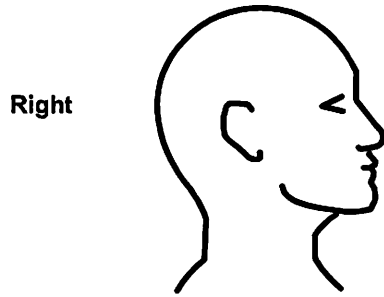
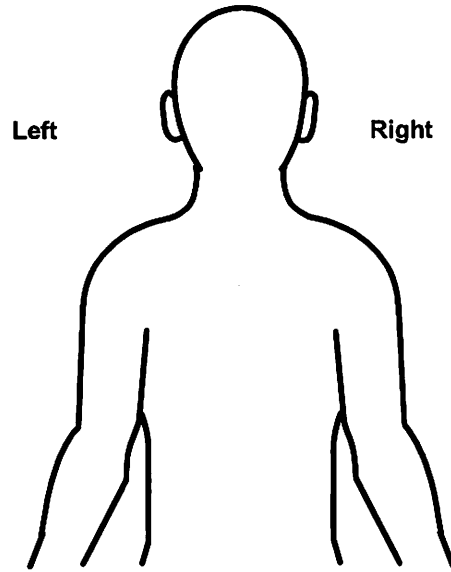
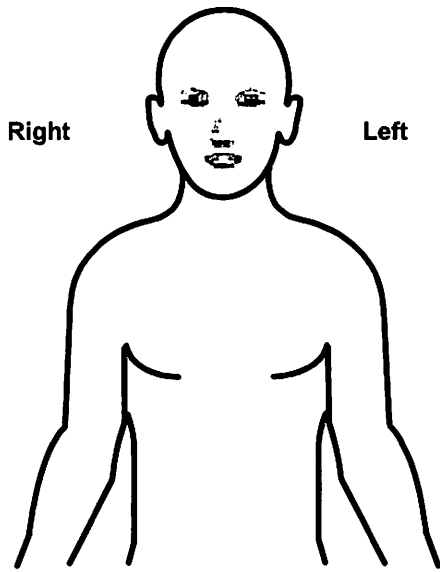
Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____

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: _____



Indicate Areas of Pain
Following the Pain Scale:
1 Mild pain
2 Moderate pain
3 Severe pain

Daytime Sleepiness Evaluation

For the following situations, please answer using one of the numbers on the scale

- 0 - Would never Doze
- 1 - Slight chance of Dozing
- 2 - Moderate chance of Dozing
- 3 - High chance of Dozing

Situation	Score
Sitting quietly and reading	
Watching Television	
Sitting quietly in a public place	
As a passenger in car for an hour without any breaks	
Lying down to rest during the day when circumstances allow	
Sitting and talking with another person	
Sitting after a meal when no alcohol has been consumed	
In a car, while stopped for a few minutes	
SCORE	

Nighttime Sleepiness Evaluation

Circle Response in box

Do you snore on most nights? (>3 nights per week)	Y	N
Is the snoring loud? (Can be heard through a door or a wall)	Y	N
Have you ever been told that you stop breathing or gasp for air during sleep?	Y	N
Male: Is your collar size bigger than 17 inches?	Y	N
Female: Is your collar size bigger than 16 inches?	Y	N
Have you been or are you being treated for High Blood Pressure?	Y	N
SCORE		

Signature: _____ DATE: ____/____/____

**AUTHORIZATION TO RELEASE INFORMATION TO THE BELOW
LISTED REFERRING AND TREATING HEALTH CARE**

PROFESSIONALS:

Doctors Name

Location/Phone

I authorize the release of communications regarding my treatment with _____ including a full report of examination findings, diagnosis, treatment plan, and progress reports to the providers listed above.

Signed _____ Date _____