Patient Health Questionnaire

Name: _____
First *Middle Initial* *Last*

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age:_____ Date of Birth:_____ SSN:_____ Sex: ____Male____Female

Ethnicity: ____American Indian/Alaska Native ____Asian ____Black/African American ____Hispanic/Latino
____Native Hawaiian/Pacific Islander ____White ____Other ____Decline

Patient Address:_____ City:_____State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____

Email: _____ Employer Name: _____

Family Dentist: _____ Primary Care Doctor: _____

Other Doctors: _____

How did you hear about our office?: _____

Reason(s) for this appointment: ☐ Pain ☐ Sleep/Airway ☐ Orthodontics

Responsible Party/Legal Guardian (if different than patient):_____Relationship to Patient: _____

Primary Insurance Information:

Policy Holder:_____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Employer: _____ Insurance Company:_____

Contract #: _____ Group #:_____ Provider #: _____

Additional Insurance Information:

Policy Holder:_____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Employer: _____ Insurance Company:_____

Contract #: _____ Group #:_____ Provider #: _____

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

___Anesthetics	___Codeine	___Penicillin
___Antibiotics	___Iodine	___Plastic
___Aspirin	___Latex	___Sedatives
___Barbiturates	___Metals	___Sulfa

Other:_____

For Office Use Only - Date of Completion: _____

Please number your chief complaint as 1 and all other complaints starting at 2 and increasing numerically:

___Back Pain
___Difficulty Closing Mouth
___Dizziness
___Dyskinesia
___Ear Congestion
___Ear Pain
___Ear Stuffiness
___Eye Pain
___Facial Pain
___Headache (inside head)
___Headache (outside head)
___Jaw Joint Locking
___Jaw Joint Noises
___Jaw Pain
___Limited Ability to Open
___Muscle Twitching
___Neck Pain
___Nerve Pain
___Numbness
___Pain When Chewing
___Shoulder Pain
___Sinus Congestion
___Throat Pain
___Tinnitus (Ringing in Ears)
___Vision Problems
___Acid Indigestion
___Affecting Sleep Partner
___Difficulty Falling Asleep
___Dry Mouth Upon Waking
___Fatigue
___Feel Unrefreshed in Morning
___Frequent Heavy Snoring
___Frequent Tossing & Turning
___Kicking/Jerking Legs Repeatedly
___Morning Headaches
___Morning Hoarseness in Voice
___Night Sweats
___Nighttime Choking Spells
___Nighttime Urination
___Repeated Awakening
___Short of Breath
___Sore Jaw Upon Waking
___Swelling in Ankles/Feet
___Teeth Crowding
___Teeth Grinding
___Told I Stop Breathing During Sleep
___Unable to Tolerate CPAP
___Vivid Dreams

What is your current level of head, neck, and facial pain? *0 = no pain to 10 = worst possible pain:* _____

What results are you seeking from treatment? _____

_____

Please check any dental symptoms that you are currently experiencing:

___Changes in bite
___Dental Changes
___Teeth Crowding
___Teeth Sensitivity
___Teeth Spacing
___None

Any symptoms not listed above? _____

_____

_____

In which position do you sleep?	□ Back	□ Side	□ Stomach	□ Varies
Where do you sleep?	□ Bed	□ Chair	□ Couch	□ Other
Do you have a bed partner?	□ Yes	□ No		
Is it easy for you to fall asleep?	□ Yes	□ No		
How many times do you wake during the night?	_____			
Do you feel rested upon waking?	□ Yes	□ No		
Has anyone ever told you that you stop breathing during sleep?	□ Yes	□ No		
Have you ever had a sleep study?	□ Yes	□ No		

If yes: Date: _____ Location: _____

Do you currently use a CPAP? ☐ Yes ☐ No

Have you had a previous oral appliance? ☐ Yes ☐ No

How many hours of sleep, on average, do you get per night? _____

How many hours of sleep, on average, during the day? _____

Do you ever cough, gasp, or snort upon waking? ☐ Yes ☐ No

Please list all medications you are currently taking and the reason you are taking the. Include prescription, over the counter, vitamins, herbs, etc. (Please attach additional sheet if necessary)

Medication	Dosage	Reason for Taking

Previous treatments/medications for the condition we are evaluating:

Treatment/Medication	Doctor/Provider	Approximate Date of Treatment

Have you had prior orthodontic treatment? ☐ Yes ☐ No

Have you had sustained injury to: ☐ Head ☐ Neck ☐ Face ☐ Teeth

Other:_____

Please indicate if you have had any of the following:

___General Anesthesia
___Adenoids Removed
___Tonsils Removed
___Jaw Joint Surgery
___Orthognathic Surgery
___Oral Surgery
___Removal of Wisdom Teeth
___Nasal Surgery

Other Surgeries:_____

Do you have trouble breathing through your nose? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

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

Do you smoke tobacco? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

If yes: ☐ Socially ☐ Habitually

Do you take any sedatives/medications/supplements to help yourself fall asleep at night? ☐ Yes ☐ No

If yes: What? _____

Do you have or have you experienced any of the following?

___Anemia
___Anxiety
___Asthma
___Birth Defects
___Bleeding Easily
___Bruising Easily
___Cancer
___Chronic Fatigue
___Cold Hands and Feet
___Depression
___Diabetes
___Difficulty Breathing at Night
___Difficulty Concentrating
___Dizziness
___Ehlers-Danlos Syndrome (EDS)
___Emphysema
___Epilepsy
___Excessive Thirst
___Fainting
___Fibromyalgia
___Fluid Retention
___Frequent Awakening at Night
___Frequent Colds/Flus
___Frequent Cough
___Frequent Ear Infections
___Frequent Sore Throat
___Gastroesophageal Reflux (GERD)
___Glaucoma
___Hay Fever
___Hearing Impairment
___Heart Disorder/Heart Attack
___Heart Murmur
___Heart Pacemaker
___Heart Palpitations
___Heart Valve Replacement
___Hemophilia
___Hepatitis
___High Blood Pressure
___History of Substance Abuse
___Huntington's Disease
___Hypoglycemia
___Insomnia
___Intestinal Disorder
___Irregular Heartbeat
___Kidney Disease
___Leukemia
___Liver Disease
___Low Blood Pressure
___Memory Loss
___Meniere's Disease
___Migraines
___Mitral Valve Prolapse
___Muscle Aches
___Muscular Dystrophy
___Muscle Fatigue
___Muscle Spasms
___Muscle Tremors
___Multiple Sclerosis
___Nervous System Disorder
___Neuralgia
___Osteoarthritis
___Osteoporosis
___Ovarian Cyst
___Parkinson's Disease
___Poor Circulation
___Postural Orthostatic Tachycardia Syndrome (POTS)
___Psychiatric Care
___Recent Weight Gain
___Recent Weight Loss
___Rheumatoid Arthritis
___Rheumatoid Fever
___Scarlet Fever
___Shortness of Breath
___Significant Daytime Drowsiness
___Sinus Problems
___Skin Disorder
___Slow Healing Sores
___Sleep Apnea
___Speech Difficulties
___Stroke
___Swollen, Stiff, or Painful Joints
___Thyroid Problem
___Tired Muscles
___Tuberculosis
___Urinary Tract Disorder

Does your family have a history of similar conditions, symptoms, or diseases? □ Yes □ No

If yes, who:_____

Current Symptoms:

Are you currently experiencing head pain? □ Yes □ No

If yes, please indicate all that apply:

	Location			Time frame		Severity			Duration			Frequency		
	Left	Right	Bilateral	Recent	Chronic (over 6 mo.)	Mild	Moderate	Severe	Min.	Hrs.	Days	Occasional	Frequent	Constant
Temple Area (Temporal)	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Back of Head (Occipital)	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Forehead (Frontal)	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Top of Head (Parietal)	□	□	□	□	□	□	□	□	□	□	□	□	□	□
General	□	□	□	□	□	□	□	□	□	□	□	□	□	□

Are you currently experiencing jaw conditions? □ Yes □ No
If yes, please indicate all that apply:

Jaw pain with opening	□ Left	□ Right
Jaw pain when chewing	□ Left	□ Right
Jaw pain at rest	□ Left	□ Right
Jaw sounds with opening	□ Left	□ Right
Jaw sounds when chewing	□ Left	□ Right
Jaw sounds at rest	□ Left	□ Right

Please indicate if you have had any of the following:

___Jaw Locks Closed
___Jaw Locks Open
___Daytime Teeth Clenching/Grinding
___Nighttime Clenching/Grinding
___Blurred Vision
___Double Vision
___Pain/Pressure behind eyes
___Extreme Sensitivity to light
___Wear Glasses or Contact Lenses

Are you currently experiencing any ear related conditions? □ Yes □ No
If yes, please indicate all that apply:

Ear Congestion	□ Left	□ Right
Ear Pain	□ Left	□ Right
Hearing Loss	□ Left	□ Right
Itchiness or Stuffiness in Ears	□ Left	□ Right
Pain Behind the Ear	□ Left	□ Right
Pain in Front of the Ear	□ Left	□ Right
Recurrent Ear Infections	□ Left	□ Right
Ringing in the Ear	□ Left	□ Right

Please indicate if you have had any of the following:

___Chronic Sore Throat
___Difficulty Swallowing
___Swollen Gland
___Thyroid Enlargement
___Tightness in Throat
___Constant Feeling of Foreign Object in Throat
___Limited Movement of Neck
___Neck Pain
___Numbness in hands/fingers
___Swelling in the neck
___Shoulder Pain
___Shoulder Stiffness
___Tingling in hands or fingers
___Lower Back Pain
___Upper Back Pain
___Middle Back Pain
___Scoliosis
___Sciatica
___Chronic Sinusitis
___Broken Teeth
___Dry Mouth
___Frequent Biting of the Cheek
___Burning Tongue Sensation

Symptom History:

On what date, or approximate date, did your condition/symptoms first occur? _____

Can you relate your pain/condition to a motor vehicle accident or traumatic injury? □ Yes □ No

If yes, please explain: _____

Does any family member have a sleep breathing disorder or Obstructive Sleep Apnea? □ Yes □ No
If yes: Who? _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____