PATIENT HEALTH QUESTIONNAIRE (Complete, Print, and Bring to Appointment)

Patient Name:_____Mr. Mrs. Miss Dr.

Age:_____ Date of Birth:_____ Gender:_____ Height:_____ Weight:_____

Email:_____

Address:_____

Phone:_____ May we send text messages/reminders?_____

Referred by:_____ DDS MD ENT DC Other_____

Guarantor Name, Address, and Phone (if other than self):_____

_____

Type of Employment:_____

Family Dentist:_____ Phone:_____

Family Physician:_____ Phone:_____

Reason for Visit: _____Pain _____Sleep/Airway _____Orthodontia Other_____

CURRENT MEDICATIONS including over-the-counter medication, vitamins, and supplements**:**

MEDICATION NAME	DOSAGE	REASON FOR TAKING	PRESCRIBER

_____See attached list

ALLERGIES AND REACTIONS

_____

_____

_____

PREVIOUS TREATMENTS/MEDICATIONS FOR THE CONDITION WE ARE EVALUATING :

TREATMENT/MEDICATION	PROVIDER NAME and SPECIALTY	APPROXIMATE DATE

Patient Signature:_____ Date:_____

CHIEF COMPLAINTS

Please **Number** your chief complaints in order of severity: #1 bothers you the most, #2 the second, #3, #4, #5, etc. (List all of your symptoms.) In addition, if the symptom is chronic (has lasted longer than six months) indicate with a **C** or an **R** if it is a recent onset symptom.

____Headache Pain
____Tinnitus (ringing in the ears)
____Ear pain
____Ear Congestion
____Sinus Congestion
____Facial Pain
____Eye Pain
____Throat Pain
____Jaw Pain
____Back Pain
____Shoulder Pain
____Neck Pain
____Limited ability to open mouth
____Pain when chewing
____Jaw Joint Locking
____Jaw Joint Noises
____Muscle Twitching
____Swelling in ankles or feet

____Difficulty falling asleep
____Tossing and turning frequently
____Kicking or jerking legs repeatedly
____Repeated awakening
____Frequent heavy snoring
____Told I "stop breathing" during sleep
____Night-time choking spells
____Affects sleep of others
____Gasping when waking
____Feeling unrefreshed in the morning
____Dry mouth upon waking
____Morning hoarseness
____Fatigue
____Significant daytime drowsiness
____Teeth Grinding
____Teeth Crowding
____Vision Problems
____Unable to tolerate C-Pap

Other Symptoms:_____

How do any of the above symptoms affect your daily life?_____

_____

_____

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT?_____

_____

Patient Signature:_____ 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 more than 4 cups of coffe per day?
☐ Yes ☐ No Have you had prior orthodontic treatments?
☐ Yes ☐ No Trouble breathing through your nose?
☐ Yes ☐ No Do you smoke? How much?_____ How often?_____
☐ Yes ☐ No Do you consume alcohol? How much?_____ How often?_____

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 Prolapse
☐ Yes ☐ No 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 Bruise or Bleed Easily
☐ Yes ☐ No Cancer of _____
☐ Chemo ☐ Radiation
☐ Yes ☐ No Anemia
☐ Yes ☐ No Asthma
☐ Yes ☐ No Birth Defects
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Emphysma
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Gastroesphagela Reflux (GERD)
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No History of Substance Abuse
☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Hypoglycemia
☐ Yes ☐ No Huntington's Disease
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Leukemia

☐ Yes ☐ No Thyroid Problem
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Intestinal Disorder
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Migraines
☐ Yes ☐ No Skin Disorder
☐ Yes ☐ No Urinary Tract Infection
☐ Yes ☐ No Chronic Fatigue
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No Cold Hands and Feet
☐ Yes ☐ No Depression
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Excessive Thirst
☐ Yes ☐ No Fainting
☐ Yes ☐ No Fluid Retention
☐ Yes ☐ No Frequent Cold/Flu
☐ Yes ☐ No Frequent Cough/Sore Throat
☐ Yes ☐ No Frequent Ear Infections
☐ Yes ☐ No Hearing Impairment
☐ Yes ☐ No Memory Loss
☐ Yes ☐ No Sinus Issues
☐ Yes ☐ No Insomnia
☐ Yes ☐ No Muscle Aches
☐ Yes ☐ No Muscle Spasms/Tremors
☐ Yes ☐ No Poor Circulation
☐ Yes ☐ No Psychiatric Care
☐ Yes ☐ No Recent Weight Change
☐ Loss ☐ Gain

Patient Signature:_____ Date:_____

HEALTH AND MEDICAL HISTORY (CONTINUED)

☐ Yes ☐ No Meiniere's Disease
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Muscular Dystrophy
☐ Yes ☐ No Neuralgia
☐ Yes ☐ No Osteoarthritis
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Parkinson's Disease
☐ Yes ☐ No Rheumatoid Arthritis

☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Slow Healing Wounds
☐ Yes ☐ No Speech Difficulties
☐ Yes ☐ No Swollen, Stiff, Painful Joints
☐ Yes ☐ No Tired Muscles
☐ Yes ☐ No Ovarian Cysts
☐ Yes ☐ No Rheumatic Fever
Other:_____

SURGICAL HISTORY Have you had any of the following and the approximate date:

☐ Yes ☐ No Adenoids Removed _____
☐ Yes ☐ No Tonsils Removed _____
☐ Yes ☐ No Jaw Joint Surgery _____
☐ Yes ☐ No Orthognathic Surgery _____
☐ Yes ☐ No Oral Surgery _____
☐ Yes ☐ No Wisdom Teeth Removed _____

List any other surgeries and approximate dates:_____

_____

_____

_____

CURRENT SYMPTOMS

Head Pain

Location				***Recent***	***Chronic***	***Severity***			***Duration***			***Frequency***		
Left	*Right*	*Bilateral*			*(over 6 mos)*	*Mild*	*Med*	*Severe*	*Min.*	*Hrs.*	*Days*	*Occas.*	*Frequent*	*Constant*
☐	☐	☐	Frontal (forehead)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Generalized	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Parietal (top of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Occipital(back of head)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	☐	Temporal(temple area)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have pain or discomfort in any of the following areas? If so, approximately when did it begin?

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

Patient Signature:_____ Date:_____

CURRENT SYMPTOMS (CONTINUED)

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 stuffiness in the ears
☐ **L** ☐ **R** Pain behind the ear
☐ **L** ☐ **R** Pain in front of the ear
☐ **L** ☐ **R** Recurrent ear infections
☐ **L** ☐ **R** Ear Ringing (Tinnitis)

Eye Related Conditions

☐ Yes ☐ No Blurred Vision
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Eye Pain
☐ Yes ☐ No Pressure behind the eyes
☐ Yes ☐ No Extreme sensitivity to light
☐ Yes ☐ No Wear glasses or contacts

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

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

Throat Related Conditions

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

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 cheek

Patient Signature:_____ Date:_____

Sleep Conditions Please answer based on your average sleep and/or what your sleep partner has told you.

Sleep Position ☐ Side ☐ Back ☐ Stomach ☐ Varies Average hours of sleep per night?_____

I fall asleep easily. ☐ Yes ☐ No I often wake during the night. ☐ Yes ☐ No

I gasp/choke during the night. ☐ Yes ☐ No I feel rested upon AM wakening. ☐ Yes ☐ No

I have had a sleep study (PSG). ☐ Yes ☐ No The result of study was_____

HISTORY OF CURRENT SYMPTOMS

When did you notice these symptoms begin (approximate date)?_____

Which if any of your immediate family members share these symptoms?_____

Are any of your symptoms a result of a trauma or motor vehicle accident?_____

Please describe the incident:_____

_____

_____

_____

THE EPWORTH SLEEPINESS SCALE (ESS)

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.

How likely are you to doze off or fall asleep in the following situations in contrast to feeling "just tired"? Score the situations as your usual way of life in the present and in the recent past. Even though you may have not done some of these things recently, score them as you believe they would have affected you.

Score the situations as follows:

0 = would **NEVER** doze

1 = **SLIGHT** chance of dozing

2 = **MODERATE** chance of dozing

3 = **HIGH** chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading……	_____
Watching television……	_____
Sitting inactively in a public place (e.g. theatre, meeting)……	_____
As a passenger in a car for over an hour w/o a break……	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone……	_____
Sitting quietly after lunch without alcohol……	_____
In a car while stopped for a few minutes in traffic……	_____
TOTAL SCORE……	_____

Patient Signature:_____ Date:_____

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