HIGH PEAKS DENTAL

Patient Health Questionnaire

Patient Information

Name: _____
First Middle Last

Date of Birth: _____ Age: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Email: _____

Responsible Party (if different than Patient): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Email: _____

Referred by: _____

Family Dentist: _____ Phone number: _____

Family Physician: _____ Phone number: _____

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

WHAT IS THE CHIEF COMPLAIN FOR WHICH YOU ARE SEEKING TREATMENT IN OUR OFFICE?
(Please identify your chief complaint as #1, list all other symptoms in priority #2-9)

Priority	Symptom	Recent	Chronic	Priority	Symptom	Recent	Chronic
	Headache pain	□	□		Kicking or jerking leg repeatedly	□	□
	Ear pain	□	□		Swelling in ankles or feet	□	□
	Jaw pain	□	□		Morning Hoarseness	□	□
	Pain when chewing	□	□		Dry mouth upon waking	□	□
	Facial pain	□	□		Fatigue	□	□
	Eye pain	□	□		Difficulty falling asleep	□	□
	Throat pain	□	□		Tossing and turning frequently	□	□
	Neck pain	□	□		Repeated awakening	□	□
	Shoulder pain	□	□		Feeling un-refreshed in the morning	□	□
	Back pain	□	□		Significant daytime drowsiness	□	□
	Limited ability to open mouth	□	□		Frequent heavy snoring	□	□
	Jaw Joint locking	□	□		Affects sleep of others	□	□
	Jaw joint noises	□	□		Gasping when waking	□	□
	Ear congestion	□	□		Told that “I stop breathing” during sleep	□	□
	Dizziness	□	□		Nighttime choking spells	□	□
	Tinnitus (ringing in the ears)	□	□		Unable to tolerate C-pap	□	□
	Muscle Twitching	□	□		Tooth grinding	□	□
	Vision problems	□	□		Teeth crowding	□	□

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

Other Comments: _____

_____

Do any of the above complains or concerns affect your daily life? _____

_____

WHAT ARE THE RESULTS YOU ARE SEEKING FROM THE TREATMENT?

_____

_____

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 □ Barbiturates □ Metals □Sulfa
□ Other: _____

Current Medications

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

Medication	Dosage	Reasons for taking

Previous Treatments/Medications

Please list any previous treatments or medications recommended by any doctor or provider for the conditions that 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

Are you currently pregnant? □ Yes □ No

Due Date: _____

Have you sustained injury to: □ Head □ Neck □ Face □ Teeth □ Other: _____

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 (for pain relief or sleeping)? □ Yes □ No

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

□ Heart Disorder/Heart Attack
□ Heart murmur
□ Mitral Valve Prolapse
□ Heart Pacemaker
□ Heart Valve Replacement
□ Irregular Heartbeat
□ Blood Pressure _____ High _____Low
□ Stroke
□ Bleeding Easily
□ Bruising Easily
□ Cancer of _____
Chemo _____ Radiation _____
□ Anemia
□ Asthma
□ Birth Defects
□ Diabetes
□ Epilepsy
□ Emphysema
□ Glaucoma
□ Gastro esophageal Reflux (GERD)
□ 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
□ 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 at night for sleep
□ Dizziness
□ Excessive Thirst
□ Fainting
□ Fluid Retention
□ Frequent colds/flu
□ Frequent cough
□ Frequent ear infections
□ Frequent sore throat
□ Frequent awaking at night - number of times __
□ 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

- □ Ovarian Cyst
- □ Parkinson's Disease
- □ Rheumatic Fever
- □ Rheumatoid Arthritis
- □ Scarlet Fever
- □ Shortness of breath
- □ Slow healing sores
- □ Speech difficulties
- □ Swollen, stiff or painful joints
- □ Tired muscles

Additional information:

_____
_____
_____

Surgical History

Have you had any of the following:

- □ General Anesthesia
- □ Adenoids removed
- □ Tonsils removed
- □ Jaw Joint Surgery
- □ Orthognathic Surgery
- □ Oral Surgery
  - o Removal of third molars (wisdom teeth)
  - o Other _____
- □ Other Surgery:
  _____
  _____

Current Symptoms

Head Pain

Location L= Left R= Right B=Bilateral		Recent	Chronic	Severity			Duration			Frequency		
				Mild	Mod	Severe	Min	Hrs.	Days	Occ	Freq	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)	□	□	□	□	□	□	□	□	□	□	□

Jaw Pain

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

Jaw Locking

□ Yes □ No Jaw locks when closed
□ Yes □ No Jaw locks open

Eye Related Conditions

□ Yes □ No Blurred Vision
□ Yes □ No Double Vision
□ Yes □ No Eye Pain

Ear Related Conditions

□ Left □ Right Buzzing in ears
□ Left □ Right Ear congestion
□ Left □ Right Ear pain
□ Left □ Right Hearing Loss
□ Left □ Right Itchiness or stuffiness in ears

Throat Related Conditions

□ Yes □ No Chronic sore throat
□ Yes □ No Difficulty swallowing
□ Yes □ No Swollen Glands

Neck Related Conditions

□ Yes □ No Limited movement of neck
□ Yes □ No Neck pain

Jaw Joint Symptoms

□ Yes □ No Teeth Clenching □Day □Night
□ Yes □ No Teeth Grinding □Day □Night

□ Yes □ No Pain or pressure behind the eyes
□ Yes □ No Extreme sensitivity to light (photophobia)
□ Yes □ No Wear of glasses or contact lenses

Shoulder Related Conditions

□ Yes □ No Shoulder pain
□ Yes □ No Shoulder stiffnes
□ 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

Jaw Joint Symptoms (cont)

□ Left □ Right Pain behind ear
□ Left □ Right Pain in front of the ear
□ Left □ Right Recurrent ear infections
□ Left □ Right Ringing in the ear (Tinnitus)

□ Yes □ No Thyroid enlargement
□ Yes □ No Tightness in throat
□ Yes □ No constant feeling of foreign object in throat|

□ Yes □ No Numbness in hands or fingers
□ Yes □ No Swelling in the neck

Sleep Conditions

Sleep positions □ Side □ Back □Stomach □Varies

Is it easy to fall asleep? □ Yes □ No
Do you feel rested upon waking? □ Yes □ No
Stopped breathing during sleep? □ Yes □ No

Average hours of sleep per night? _____
Do you wake often during the night? □ Yes □ No
Gasping or choking during sleep? □ Yes □ No
Have you ever had a Sleep Study (PSG)? □ Yes □ No
Result was? _____

History of Symptoms

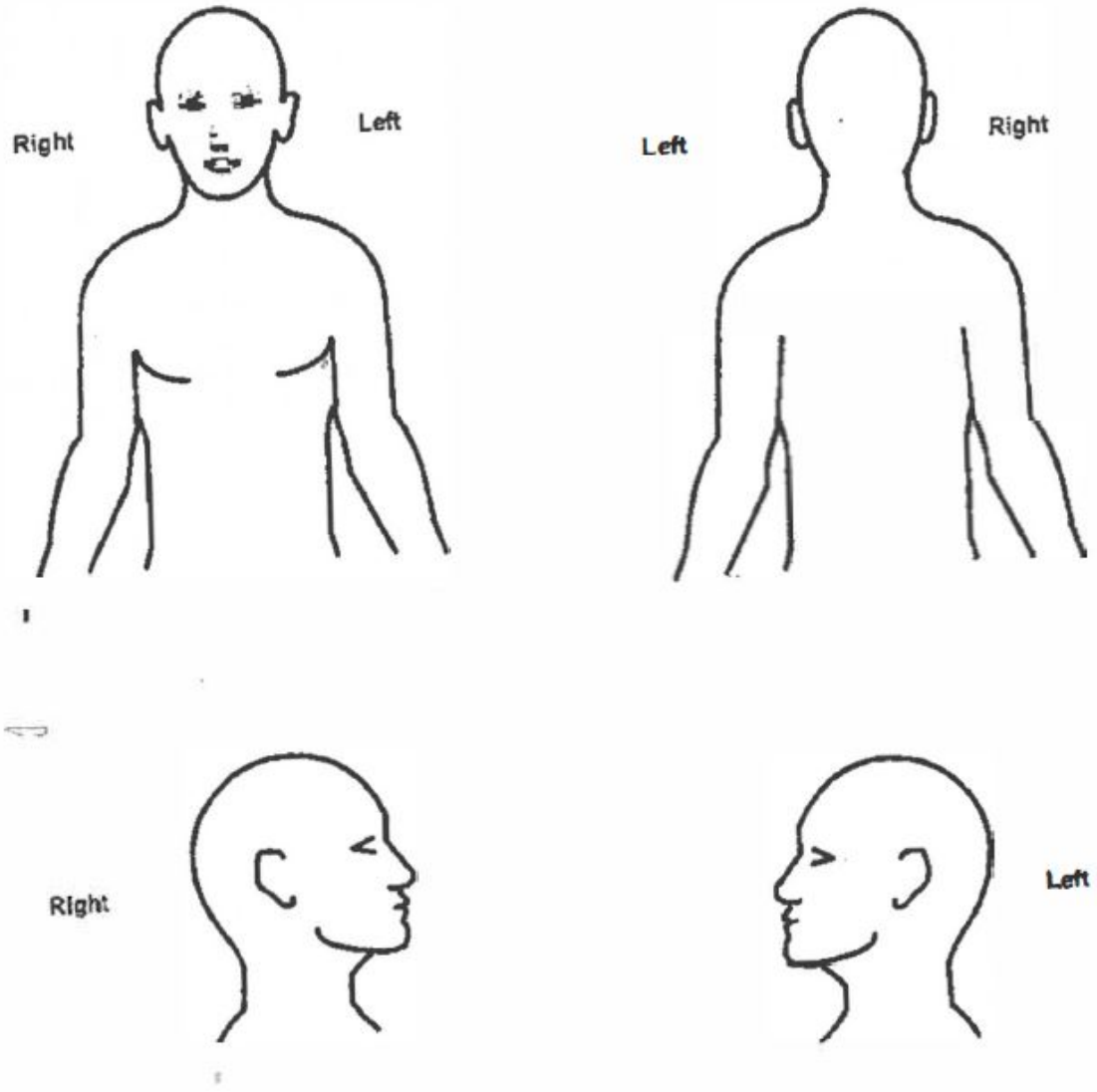
On what date, or approximate date, did this condition or symptoms fist occur? _____

□ Yes □ No Does any family member have the same or similar problem?
If yes, explain. _____

Can you relate your pain or condition to a motor vehicle accident or traumatic injury? _____
If yes, explain.
_____
_____

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any refening 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_____ Date: _____
(If patient is a minor)



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