



PATIENT HEALTH QUESTIONNAIRE

Patient's Name: _____ Today's Date: _____

Address: _____ City: _____ State _____ Zip _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____

1. What is your major concern about your mouth or teeth?

2. Describe your oral / dental health:

3. Date of last dental exam: _____

4. Describe your general health:

5. Date of last physical exam: _____

6. Has there been **any change in your general health in the past year?** ___ Yes ___ No
If yes, what condition? _____

7. Are you **presently** under a physicians care? ___ Yes ___ No
If yes, please explain: _____

8. Have you been **hospitalized** within the past 5 years? ___ Yes ___ No
If yes, explain: _____

9. Your physician's name and address: _____
Telephone: (____) – _____

10. List all medications you are taking (or supposed to take) including over the counter medications, Aspirin, birth control pills or hormones (if none, so state):

Medication	-	Dosage	-	Time / Day
	-		-	
	-		-	
	-		-	
	-		-	
	-		-	

Medical History**Patient Name:** _____**Date of Birth:** _____

Please indicate the appropriate answer if you have / had any of the following

Dentist's Notes

Heart / Cardiovascular

1. ___ Yes ___ No: Rheumatic Heart Disease / heart murmur
2. ___ Yes ___ No: Damaged heart valve / artificial heart valve
3. ___ Yes ___ No: Mitral valve prolapse
4. ___ Yes ___ No: Congenital heart disease
5. ___ Yes ___ No: High blood pressure
6. ___ Yes ___ No: Low blood pressure
7. ___ Yes ___ No: Arteriosclerosis / High cholesterol
8. ___ Yes ___ No: Chest pain after exertion
9. ___ Yes ___ No: Shortness of breath after mild exercise
10. ___ Yes ___ No: Heart attack
11. ___ Yes ___ No: bypass surgery
12. ___ Yes ___ No: Heart pace maker / Irregular or rapid heart rate
13. ___ Yes ___ No: Stroke
14. ___ Yes ___ No: Do your ankles swell?
15. ___ Yes ___ No: Do you use extra pillows to sleep?
16. ___ Yes ___ No: Other heart problems?

Breathing / Lungs / Sinuses

1. ___ Yes ___ No: Shortness of breath / Breathing problem
2. ___ Yes ___ No: Asthma / Hay fever
3. ___ Yes ___ No: Emphysema / COPD
4. ___ Yes ___ No: Tuberculosis / Persistent cough or cold
5. ___ Yes ___ No: Sinus problem / Sinusitis / Have a nasal problem
6. ___ Yes ___ No: Do you smoke?

Allergies To:

1. ___ Yes ___ No: Penicillin
2. ___ Yes ___ No: Sulfa
3. ___ Yes ___ No: Aspirin / Codeine / Other pain medications
- _____
4. ___ Yes ___ No: Iodine
5. ___ Yes ___ No: Sedatives / Sleeping Pills / Barbiturates
6. ___ Yes ___ No: Local Anesthetics
- _____
7. ___ Yes ___ No: Latex
8. ___ Yes ___ No: Metals
- _____
9. Other Medications: -
- _____

Blood Conditions

1. ___ Yes ___ No: Anemia
2. ___ Yes ___ No: Leukemia
3. ___ Yes ___ No: Sickle Cell trait / Disease
4. ___ Yes ___ No: Hemophilia / Excessive bleeding / Bruise easily
5. ___ Yes ___ No: Blood transfusion
6. ___ Yes ___ No: HIV positive
7. ___ Yes ___ No: Family history of blood disorder

Central Nervous System

1. ___ Yes ___ No: Epilepsy
2. ___ Yes ___ No: Fainting Spell
3. ___ Yes ___ No: Seizures
4. ___ Yes ___ No: Emotional disturbances
5. ___ Yes ___ No: Do you follow any treatment for a nervous disease?

Endocrine System

1. ___ Yes ___ No: Do you have Diabetes?
2. ___ Yes ___ No: Does anyone in your family have Diabetes?
3. ___ Yes ___ No: Hypothyroidism / Hyperthyroidism
4. ___ Yes ___ No: Are you thirsty very often / Have a dry mouth?

Digestive System

1. ___ Yes ___ No: Stomach ulcers
2. ___ Yes ___ No: Hepatitis
3. ___ Yes ___ No: Jaundice
4. ___ Yes ___ No: Liver Disease

Bones and Joints

1. ___ Yes ___ No: Arthritis
2. ___ Yes ___ No: Inflammatory Rheumatism
3. ___ Yes ___ No: Bone infection
4. ___ Yes ___ No: Artificial joints
5. ___ Yes ___ No: Osteoporosis

Other

1. ___ Yes ___ No: Kidney trouble
2. ___ Yes ___ No: Dialysis
3. ___ Yes ___ No: Syphilis / Gonorrhea
4. ___ Yes ___ No: Lupus / Auto Immune Disease
5. ___ Yes ___ No: Do you have glaucoma?

If yes, what type: Narrow angle: _____ Open angle: _____

Neoplasm

1. ___ Yes ___ No: Cancer / Tumor

If yes, what kind? _____

2. ___ Yes ___ No: Chemotherapy

If yes, what medications? _____

3. ___ Yes ___ No: Radiation Therapy

General

1. ___ Yes ___ No: Do you have or have you ever had any condition, disease, or problem NOT listed above that you think I should know about?

If yes, explain:

2. ___ Yes ___ No: Do you Drink Alcohol?

If yes, how much and how often? _____

3. ___ Yes ___ No: Do you smoke?

If yes, how much? _____

4. ___ Yes ___ No: Do you use oral tobacco?

If yes, how much and how often? _____

Women Only

1. ___ Yes ___ No: Are you pregnant or suspect being pregnant?
2. ___ Yes ___ No: Are you nursing?
3. ___ Yes ___ No: Are you taking any oral contraception or hormonal therapy?
6. ___ Yes ___ No: Osteoporosis

VITAL SIGNS

B.P.: _____ Pulse: _____

Weight: _____ Temp : _____

AUTHORIZATION

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all the questions to the best of my knowledge. I will not hold DR. RAJIV PATEL or any other member of his staff responsible for any error or omissions that I might have made in the completion of this form. Should further information be needed, you have my permission to ask the respective healthcare provider or agency, who may release such information to you. I will notify Dr. Patel of any change in my health or medications. I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthesia as indicated. I understand that antibiotics, analgesics, anesthetics and other medications can cause allergic reactions such as redness and swelling tissue, pain, itching, vomiting and/or anaphylactic shock.

Patient's/guardian's signature

Date

Patient Name: _____ Date of Birth: _____

1. What is your chief dental complaint? _____

2. Are you experiencing any discomfort or pain? ___ Yes ___ No
3. How often do you have your dental exam? _____
4. When was your last dental visit _____
5. Do you feel nervous about dental treatment? ___ Yes ___ No
6. Have you had any serious trouble associated with any previous dental treatment? ___ Yes ___ No
7. Are you satisfied with the appearance of your teeth? ___ Yes ___ No
If NO what would you like to have changed about the way your teeth looks? _____

8. Are your teeth sensitive to hot or cold? ___ Yes ___ No
9. Do your gums bleed when you brush? ___ Yes ___ No
1. Have you noticed any bad odor or bad taste? ___ Yes ___ No
2. Do you get frequent cold sores, blisters etc.? ___ Yes ___ No
3. Do you clench or grind your teeth while awake or asleep? ___ Yes ___ No
4. Do you have tired jaw, especially mornings? ___ Yes ___ No

Have you had or experienced:

5. ___ Yes ___ No : Orthodontic treatment
6. ___ Yes ___ No : Bite adjustment
7. ___ Yes ___ No : Oral surgery
8. ___ Yes ___ No : Bite plate/mouth guard
9. ___ Yes ___ No : Periodontal Treatment
10. ___ Yes ___ No : Injury to head/mouth
11. ___ Yes ___ No : Clicking/popping of jaw
12. ___ Yes ___ No : Difficulty chewing
13. ___ Yes ___ No : Difficulty opening or closing
14. ___ Yes ___ No : Sore mouth/neck/shoulder

Do you wear dentures now? ___ Yes ___ No

___ Upper complete ___ Lower Complete ___ Upper Partial ___ Lower Partial

Since how long? _____

How old is this denture? Upper _____ Lower _____

Was it an immediate denture? ___ Yes ___ No

Do you like the **shape**? ___ Yes ___ No **Size**? ___ Yes ___ No **Color**? ___ Yes ___ No

Other Comments: _____

What's most important to you in your dental health? _____

What is most important to you when choosing a dentist? _____

Is there anytime that your mouth does not taste as well or smell as good as you would like? ___

Patient's/guardian's signature

Date