NORTH BALWYN DENTAL

QUALITY DENTISTRY TO SUIT YOUR NEEDS

PATIENT HEALTH QUESTIONNAIRE

PATIENT INFORMATION Date of completion_____

__Mr. __Ms. __Miss. __Mrs. __Dr

Name: _____
(First) (Middle) (Last)

Age: _____ Date Of Birth: _____
Referred by: _____ DDS__ MD__ ENT__ DC__ Other__
Location and/or Phone Number of Healthcare Provider: _____
Patient Address: _____ City: _____
State: _____ P/C: _____
Home Phone: _____ Alternative Contact Number: _____
Type of Employment: _____
Responsible Party (if different than patient): _____
Address: _____ City: _____
State: _____ P/C: _____
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 COMPAINT 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.

__Headache pain
__Ear pain
__Jaw pain
__Pain when chewing
__Facial pain
__Eye pain
__Throat pain
__Neck pain
__Shoulder pain
__Back pain
__Limited ability to open mouth
__Jaw joint locking
__Jaw joint noises
__Ear congestion
__Sinus congestion
__Dizziness
__Tinnitus (ringing in the ear)
__Muscle twitching
__Vision problems
__Kicking or jerking leg repeatedly
__Swelling in ankle or feet
__Dry mouth upon waking
__Fatigue
__Morning hoarseness
__Difficulty falling asleep
__Tossing and turning frequently
__Repeated awakening
__Feeling unrefreshed in the morning
__Significant daytime drowsiness
__Frequent heavy snoring
__Affects sleep of others
__Gasping when waking
__Told that "I stop breathing" during sleep
__Night time choking spells
__Unable to tolerate C-Pap
__Tooth grinding
__Tooth crowding
Other: _____

Do you have concerns in any of these areas: __General Appearance __Overbite
__Ability to Function __Smile

Other comments:
_____
_____

WHAT ARE THE RESULTS YOU ARE SEEKING FROM TREATMENT? _____
_____

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

__Anaesthetic __Codeine __Penicillin
__Antibiotics __Iodine __Plastic
__Aspirin __Latex __Sedatives
__Barbiturates __Metals __Sulfa
__Other (Please specify) _____

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
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 communication with the providers listed above.

Patient Signature: _____ Date:_____

HEALTH AND MEDICAL HISTORY

__Yes __No Are you currently pregnant?
__Yes __No Have you sustained injury to: __Head __Neck __Teeth __Other_____
__Yes __No Do you drink 4 or more cups of coffee per day?
__Yes __No Do you smoke tobacco?
__Yes __No Have you had prior orthodontic treatments?
__Yes __No Consume alcohol or take sedatives?
__Yes __No Trouble breathing through nose?

HEALTH AND MEDICAL HISTORY (CONTINUED)

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 Heart 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 Bleeding Easily
__Yes __No Bruising Easily
__Yes __No Cancer of_____
Chemo ___Radiation ___
__Yes __No Anaemia
__Yes __No Asthma
__Yes __No Birth Defects
__Yes __No Diabetes
__Yes __No Epilepsy
__Yes __No Emphysema
__Yes __No Glaucoma
__Yes __No Gastroesophogeal Reflux (Gerd)
__Yes __No Hemophilia
__Yes __No Hepatitis
__Yes __No History of Substance Abuse
__Yes __No Hypoglycemia
__Yes __No Huntington's Disease
__Yes __No Kidney Disease
__Yes __No Liver Disease
__Yes __No Leukemia
__Yes __No Migraines
__Yes __No Menieres Disease
__Yes __No Multiple Sclerosis
__Yes __No Muscular Dystrophy
__Yes __No Neuralgia
__Yes __No Osteoarthritis
__Yes __No Osteoporosis
__Yes __No Ovarian Cysts
__Yes __No Parkinson's Disease
__Yes __No Rheumatic Fever
__Yes __No Rheumatoid Arthritis
__Yes __No Scarlet Fever

__Yes __No Thyroid Problem
__Yes __No Tuberculosis
__Yes __No Intestinal Disorder
__Yes __No Nervous System Disorder
__Yes __No Anxiety
__Yes __No Skin Disorders
__Yes __No Urinary Tract Disorder
__Yes __No Chronic Fatigue
__Yes __No Fibromyalgia
__Yes __No Cold hands and feet
__Yes __No Depression
__Yes __No Difficulty Concentrating
__Yes __No Difficulty breathing at night for sleep
__Yes __No Dizziness
__Yes __No Excessive Thirst
__Yes __No Fainting
__Yes __No Fluid Retention
__Yes __No Frequent colds/flu
__Yes __No Frequent cough
__Yes __No Frequent ear infections
__Yes __No Frequent sore throat
__Yes __No Frequent awakening at night.
Number of times: _____
__Yes __No Hearing impairment
__Yes __No Memory Loss
__Yes __No Hay Fever
__Yes __No Insomnia
__Yes __No Muscle Aches
__Yes __No Muscle Fatigue
__Yes __No Muscle Spasms
__Yes __No Muscle Tremors
__Yes __No Poor Circulation
__Yes __No Psychiatric Care
__Yes __No Recent Weight Gain
__Yes __No Recent Weight Loss
__Yes __No Sinus Problems
__Yes __No Shortness of Breath
__Yes __No Slow healing sores
__Yes __No Speech Difficulties
__Yes __No Swollen, Stiff or Painful Joints
__Yes __No Tired Muscles

Additional Information:

_____
_____
_____

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

__Yes __No General Anaesthesia
__Yes __No Adenoids Removed
__Yes __No Tonsils Removed
__Yes __No Jaw Joint Surgery
__Yes __No Orthognathic Surgery
__Yes __No Oral Surgery
__Yes __No Removal of third molar/s (wisdom teeth)
__Yes __No Other Surgery (Please list below)

Other Types Of Surgery:

_____
_____
_____

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS
Head Pain

Location	Recent	Chronic	Severity			Duration			Frequency		
L=Left R=Right B=Bilateral		*(Over 6 mths)*	*Mild*	*Mod*	*Severe*	*Min*	*Hrs*	*Days*	*Occasional*	*Frequent*	*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)	__	__	__	__	__	__	__	__	__	__	__

Do you have pain or discomfort in any of the following area/s? 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 Wear of glasses or contact lenses
__Yes __No Extreme sensitivity to light (Photophobia)

Ear Related Conditions
__L __R Buzzing in the ears
__L __R Ear congestion
__L __R Ear Pain
__L __R Hearing loss
__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

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

Patient Signature: _____ Date: _____

Sleep Conditions
Sleep Positions __Side __Back __Stomach
Average hours of sleep per night _____
Is it easy to fall asleep? _____
Do you wake often during the night? _____
Do you feel rested upon AM waking? _____
Gasping or choking during sleep? _____
Stopped breathing during sleep? _____
Have you ever had a Sleep Study (PSG)? _____

HISTORY OF SYMPTOMS
On what date, or approximate date, did this condition or symptom first occur? _____
__Yes __No Does any family member have the same or similar problem? If Yes, please explain below:
_____
_____

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

I authorise the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorise 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: _____

DAYTIME SLEEPINESS EVALUATION

Epworth Sleepiness Scale

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.

For the following situations, answer with one of the following numbers:

0 – Would never doze

1 – Slight chance of dozing

2 – Moderate chance of dozing

3 – High chance of dozing

SITUATION	**SCORE**
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	**_____**

NIGHTTIME SLEEPINESS EVALUATION
Screening Tool for Sleep Apnea

In whom should apnea be considered? If you suspect sleep apnea, ask your patient the following questions:

1. Snoring

a) Do you snore on most nights (>3 nights per week)?

Yes (2) No(0) _____

b) Is your snoring loud? Can it be heard through a door or wall?

Yes(2) No(0) _____

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never(0) Occasionally(3) Frequently(5) _____

3. What is your collar size?

Male: Less than 17 inches(0) More than 17 inches(5) _____

Female Less than 16 inches(0) More than 19 inches(5) _____

4. Do you occasionally fall asleep during the day when:

a) You are busy or active?

Yes(2) No(0) _____

b) You are driving or stopped at a light?

Yes(2) No(0) _____

5. Have you had or are you being treated for high blood pressure?

Yes(1) No(0) _____

TOTAL _____

SCORE

9 points or more	**6-8 points**	**5 points or less**
Refer to sleep specialist or order sleep study	Gray area, use clinical judgment	Low probability of sleep apnea

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