PATIENT HEALTH QUESTIONNAIRE
Prairie View Orthodontics. Ltd.

Information is for our records only and will be considered confidential. Please respond to all items.

Patient's Name: ______________________ Date of Birth: __________ Today's Date: ____________

Name of your medical doctor: ______________________ Date of last doctor visit: ______________

Have you been under medical care any time during the last two years? YES NO
If so, what was the problem? ______________________________________

Have you ever had any operations, hospitalizations, serious accidents or injuries? YES NO
If so, describe? ______________________________________

Are you taking any kind of drugs, pills, medications? YES NO
If so, what are you taking? ______________________________________

Have you ever taken fenfluramine (Pondimin), dexphenfluramine (Redux) or fen-phen? YES NO

Are you allergic or sensitive to penicillin or any other medications? YES NO
If so, what? ______________________________________

Are you sensitive to nickel, latex or any other substance? YES NO
If so, what?

Females: are you pregnant? YES NO POSSIBLY

Circle any of the following you have had:
hepatitis arthritis diabetes jaundice cancer high blood pressure allergies HIV infection AIDS anemia
hemophilia major surgery tuberculosis heart murmur stroke kidney disease asthma blood transfusion
rheumatic or scarlet fever artificial joints tonsils or adenoids removed sickle cell anemia seizures

Do you have ongoing trouble breathing through your nose? YES NO

Have you ever had an accident or injury involving your face or teeth? YES NO
If so, briefly explain ______________________________________

When did you last visit the dentist? ______________ His/her name: ______________________

Do you clench or grind your teeth? YES NO

Have you ever had periodontal (gum) treatment? YES NO

Have you ever experienced noises in your jaw joints? YES NO
If yes: does the noise bother you? __________ How long have you had it? __________

Has your jaw ever locked open or closed? YES NO

Is there anything you would like to change about your teeth, smile or bite? ______________

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I give permission for the use of photographs and records made in the process of examination, treatment and retention for the purpose of research, education, or publication in professional journals. YES NO

Signature of person filling out this form ______________________________________
Relationship to patient: ( ) self ( ) parent ( ) legal guardian ( ) other, please describe ______________

THANK YOU