Patient Health Questionnaire

Name _____

Reason for your visit today: _____

Please answer the following questions about your general health.

What is your impression of your general health? _____
When was the last time you were examined by a physician? _____
Height _____ Weight _____ Birthdate _____

Please circle any of the following which you have had or have now. Indicate the year for previous conditions:

Angina pectoris	High blood pressure	Covid-19	Prosthetic Joint:
Chest pains	Prolonged bleeding	Cancer	hip
Rheumatic fever	Anemia	Radiation Treatment	knee
Heart disease	Hepatitis	Chemotherapy	other:
Heart murmur	Allergies	Kidney problems	_____
Artificial heart valve	Ulcer	Arthritis	TMJ problems
Asthma	AIDS/HIV positive	Psychiatric treatment	Diabetes
Tuberculosis	Alcoholism	Epilepsy/seizures	Type I / Type II
Lung problems	Drug use	Fainting spells	Most recent HbA1C:
Injury to jaws/face	Steroid therapy	Sleep Apnea	_____

Do you have any diseases/conditions not listed above? **Yes / No If yes, please explain:**

_____

Have you had any surgeries or hospitalizations within the last 10 years? **Yes / No If yes, please list what year:**_____

_____

Are you presently taking any medication(s)? _____ **Yes / No**
If yes, please list them _____

_____

Have you ever taken Fosamax, Boniva or Actonel? _____ **Yes / No**
If Yes, how many years did you take it? _____
Do you use tobacco? If so, how much and what type? _____ **Yes / No**
Do you use alcohol? # of average drinks per week? _____ **Yes / No**
Are you allergic to any medication? _____ **Yes / No**
Have you ever had a reaction to a local anesthetic? _____ **Yes / No**
Have you ever had complications from dental treatment? _____ **Yes / No**
Are you presently having problems in your mouth or involving your face? _____ **Yes / No**
Please Explain:
When did you last have your teeth cleaned? _____
First time patients: Have you ever had treatment for gum disease? _____ **Yes / No**
WOMEN: Are you pregnant? **Yes / No** If yes, what trimester? **1 - 2 - 3**

PATIENT'S SIGNATURE: _____ **DATE:** _____

Date_____ BP/P_____ BP/P _____ BP/P

Doctor's Notes

Yorktown Periodontics