Patient Health Questionnaire
HAMPTON ROADS PERIODONTICS & IMPLANTS
Sayward E. Duggan, DDS, MS

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	
Asthma	AIDS/HIV positive	Psychiatric treatment	**Diabetes**
Tuberculosis	Alcoholism	Epilepsy/seizures	Type I / Type II
Lung problems	Drug use	Fainting spells	Recent **HbA1C:**
Injury to jaws/face	Steroid therapy	Sleep Apnea	_____
Thyroid disorder	TMJ problems	GERD	

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 surgeries and what year:** _____
_____

Please list current medication(s) including any blood thinners: _____

_____
Have you ever been prescribed a medication for osteoporosis or osteopenia (e.g.: Boniva, Fosamax, Prolia, Actonel) Yes / **No**
If yes, what years did you take it? _____ to _____
Do you use tobacco or vape? If so, how much, and what type? _____ **Yes / No**
Do you use alcohol? If so, # 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 : _____ Temp : _____

Doctor's Notes