



Evan Lyle Berson, D.M.D., P.C.

The Highest Quality Dentistry with the Softest Touch

Quality Dentistry

- Cosmetics
- Implants
- Periodontics
- Crowns
- Bridges
- Reconstructions
- TMJ
- Dentures
- Endodontics
- Sports Dentistry

Softest Touch

- Modern Techniques
- State-of-the-Art Equipme
- Relaxation Techniques
- Stereo Headphones
- Laughing Gas
- Painless Dentistry

HEALTH HISTORY

INSTRUCTIONS: This questionnaire will help us to understand your problem and should be completed **BEFORE** your first appointment. We know that this form is long and will take time, but please read and answer every question carefully so that we can make the correct diagnosis. Try to answer these questions by **YOURSELF**, without any assistance from anyone else, if possible.

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME TEL. () _____ OCCUPATION _____

FIRM'S NAME AND ADDRESS: _____

_____ TEL. () _____

BIRTHDATE: ____ / ____ / ____ SEX: Male Female

MARITAL STATUS: Single Married Divorced Remarried Separated Widowed

NUMBER OF CHILDREN: _____ AGES OF CHILDREN: _____

SPOUSE'S NAME: _____ OCCUPATION: _____

INSURANCE CARRIER: _____ Policy # _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

OTHER INSURANCE: _____ Policy # _____

CURRENT EMPLOYMENT STATUS?

- | | | |
|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Employed full time | <input type="checkbox"/> Homemaker | <input type="checkbox"/> STUDENT |
| <input type="checkbox"/> Employed part time | <input type="checkbox"/> Disabled | |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Unemployed | |

WHO REFERRED YOU?

NAME: _____ TEL: () _____

ADDRESS: _____ ZIP: _____

NAME OF FAMILY DENTIST: _____

ADDRESS: _____ TEL: () _____

NAME OF FAMILY PHYSICIAN: _____

ADDRESS: _____ TEL: () _____

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301 City Line Avenue • Bala Cynwyd, PA 19004 • 610-667-6666

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Nerve disorder	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Epstein-Barr virus	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/urinary disease	<input type="checkbox"/>	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung disorders	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE?

	YES	NO
An implanted pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Swollen, stiff, or painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Generalized aches and pains	<input type="checkbox"/>	<input type="checkbox"/>
Multiple tender spots	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in hands, fingers, or scalp	<input type="checkbox"/>	<input type="checkbox"/>
Frequent muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness and constant fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps at night or when walking	<input type="checkbox"/>	<input type="checkbox"/>
Nails that break easily	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to cold weather	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY

Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you menstruate regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take estrogen?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ANY CURRENT MEDICATIONS YOU ARE TAKING:

	NAME	DOSAGE	# TAKEN DAILY
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____

PLEASE LIST ANY OTHER DRUGS YOU HAVE USED IN THE PAST FIVE YEARS FOR YOUR SYMPTOMS:

1)	_____	5)	_____
2)	_____	6)	_____
3)	_____	7)	_____
4)	_____	8)	_____

HISTORY: Please refer back to your main problem(s) and answer the following questions:

- A. When did you first notice the symptoms? _____
- B. What caused the onset of this condition:
- | | |
|--|---|
| <input type="checkbox"/> Auto accident | <input type="checkbox"/> Following illness |
| <input type="checkbox"/> Accident at home | <input type="checkbox"/> Medical/dental treatment |
| <input type="checkbox"/> Accident at work | <input type="checkbox"/> Stressful situation |
| <input type="checkbox"/> Whiplash injury | <input type="checkbox"/> Pain "just began" |
| <input type="checkbox"/> Following surgery | <input type="checkbox"/> Other (specify) |

- C. How fast did the condition arise? Over months Over weeks Over days In one day
- D. How has the condition changed since it began? Increased Decreased Stayed the same
- E. Since your condition began, which of the following practitioners have you consulted for treatment?
Indicate year and number of visits.

	Year	Major Relief	Some Relief	No Change	Felt Worse
Acupuncturist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose, throat	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrinologist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General practitioner	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gynecologist/OB	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurosurgeon	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritionist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ophthalmologist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral surgeon	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteopath	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surgeon (general)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WHAT MAKES YOUR SYMPTOMS WORSE?

- 1) _____
- 2) _____
- 3) _____
- 4) _____

WHAT KIND OF THINGS DECREASE YOUR SYMPTOMS?

- 1) _____
- 2) _____
- 3) _____
- 4) _____

HOW OFTEN DO YOUR SYMPTOMS OCCUR?

- Continuously Several times a day Once a day Several times a week
- Several times a month Once a month Less than once a month

WHEN YOUR SYMPTOMS OCCUR, HOW LONG DO THEY LAST?

- Continuously For weeks For days For hours
- For minutes For seconds Variable: _____

WHEN ARE YOUR SYMPTOMS WORSE?

- Upon arising Morning Afternoon Evening During sleep

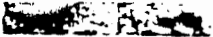
WHICH WORD GROUP BEST DESCRIBES THE PATTERN OF YOUR PAIN?

- continuous, steady, constant
- rhythmic, periodic, intermittent
- brief, momentary, transient

HAS ANYONE IN YOUR FAMILY HAD A SIMILAR CONDITION?

- no yes If yes, please explain: _____
- _____
- _____
- _____
- _____
- _____

ON THE FOLLOWING DRAWINGS:

1. Mark the **areas** where you have pain by shading in the areas with a pencil. 
2. Mark the **exact spot(s)** where the pain begins with a solid dot (●).
3. Indicate any areas of numbness (loss of feeling) with the following // // // // // .

Right



Left



Front



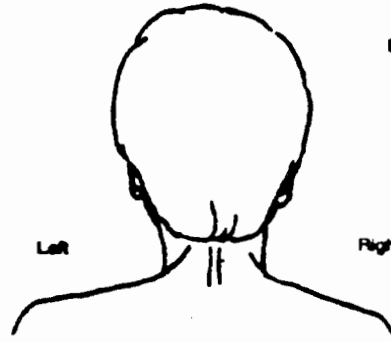
Back

Right

Left

Left

Right



PAIN EXPERIENCE:

Complete this section only if PAIN is one of your chief complaints. Some of the groups below contain words that describe your PRESENT pain. Circle only ONE word in each group which best describes how it feels. If a group does not apply to you, leave it out.

1
Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding

2
Jumping
Flashing
Shooting

3
Pricking
Boring
Drilling
Stabbing
Lancinating

4
Sharp
Cutting
Lacerating

5
Pinching
Pressing
Gnawing
Cramping
Crushing

6
Tugging
Pulling
Wrenching

7
Hot
Burning
Scalding
Searing

8
Tingling
Itchy
Smarting
Stinging

9
Dull
Sore
Hurting
Aching
Heavy

10
Tender
Taut
Rasping
Splitting

11
Tiring
Exhausting

12
Sickening
Suffocating

13
Fearful
Frightful
Terrifying

14
Punishing
Gruelling
Cruel
Vicious
Killing

15
Wretched
Blinding

16
Annoying
Troublesome
Miserable
Intense
Unbearable

17
Spreading
Radiating
Penetrating
Piercing

18
Tight
Numb
Drawing
Squeezing
Tearing

19
Cool
Cold
Freezing

20
Nagging
Nauseating
Agonizing
Dreadful
Torturing

EFFECT OF PAIN ON DAILY LIVING:

How would you rate your facial/head pain at the present time using a 0 to 10 scale where 0 is "no pain" and 10 is "pain as bad as could be." Circle the most accurate number.

No pain Pain as bad as could be
0 1 2 3 4 5 6 7 8 9 10

In the past 6 months, on the average, how intense was your pain? Please use the scale below.

No pain Pain as bad as could be
0 1 2 3 4 5 6 7 8 9 10

About how many days in the last 6 months have you been kept from your usual activities (work, school, housework) because of your problems? _____ Days

Please indicate how much facial/head pain has changed your ability to take part in recreational, social, and family activities where 0 is "no change" and 10 is "extreme change."

No change Extreme change
0 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY:

Are you otherwise in good health? yes no

When was your last routine physical? _____

Are you being treated for anything other than your current condition? yes no

If yes, explain: _____

Please list any operations and hospitalizations you have had and the dates they occurred:

- 1) _____
- 2) _____
- 3) _____

Please list any trauma or accidents you have had and dates:

- 1) _____
- 2) _____
- 3) _____

LIFESTYLE

PLEASE ANSWER EACH QUESTION WITH ONE VERTICAL SLASH (/) MARK ON EACH LINE. WHAT IS YOUR USUAL LEVEL?

Activity	Lie in bed all day	Rest half the day	Rest few times a day	Active all day
Exercise	None	Very little	Work around house	Moderate Regular
Social Activity	None	Very little	Moderate	Very active
Eating	Do not eat	Poor appetite eat lightly	Mostly snack	Eat well
Caffeine Beverages	None	1-2 daily	3-4 daily	Over 6 daily Not aware
Take Vitamins	None	Occasionally	Daily	Use megadoses
Alcoholic Beverages	None	On occasion	1-2 daily	3-4 daily More than 4 daily
Smoke Tobacco	None	On occasion	Less than 1 pack/day	More than 1 pack/day
Recreational Drugs	None	On occasion	Once per day	More than once per day

WHAT DO YOU HOPE TO GAIN FROM TREATMENT _____

CONSENT FOR REPORTS:

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ABOVE INFORMATION IS CORRECT AND I GIVE PERMISSION TO SEND A WRITTEN REPORT TO MY REFERRING AND TREATING DOCTORS BASED ON THE INFORMATION PROVIDED:

Patient/parent/guardian signature

date