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?

❑ Employed full time
❑ Employed part time
❑ Retired
❑ Homemaker
❑ Disabled
❑ Unemployed
❑ STUDENT

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	☐	☐	Nerve disorder	☐	☐
Osteoarthritis	☐	☐	Diabetes	☐	☐
High blood pressure	☐	☐	Thyroid disease	☐	☐
Heart disease	☐	☐	Cancer	☐	☐
Mitral valve prolapse	☐	☐	Venereal disease	☐	☐
Heart murmur	☐	☐	HIV/AIDS	☐	☐
Blood disease	☐	☐	Epstein-Barr virus	☐	☐
Kidney/urinary disease	☐	☐	Lyme disease	☐	☐
Lung disorders	☐	☐	Fibromyalgia	☐	☐
Asthma	☐	☐	Chronic fatigue	☐	☐
Liver disease	☐	☐	Emotional problems	☐	☐
Hepatitis	☐	☐	_____	☐	☐
Ulcers/colitis	☐	☐	_____	☐	☐

DO YOU HAVE?	YES	NO
An implanted pacemaker	☐	☐
Swollen, stiff, or painful joints	☐	☐
Generalized aches and pains	☐	☐
Multiple tender spots	☐	☐
Numbness in hands, fingers, or scalp	☐	☐
Frequent muscle spasm	☐	☐
Cold hands or feet	☐	☐
Tiredness and constant fatigue	☐	☐
Leg cramps at night or when walking	☐	☐
Nails that break easily	☐	☐
Dry skin	☐	☐
Intolerance to cold weather	☐	☐
Constipation	☐	☐
WOMEN ONLY		
Are you pregnant?	☐	☐
Do you menstruate regularly?	☐	☐
Do you take estrogen?	☐	☐

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:

- ❑ Auto accident
- ❑ Accident at home
- ❑ Accident at work
- ❑ Whiplash injury
- ❑ Following surgery
- ❑ Following illness
- ❑ Medical/dental treatment
- ❑ Stressful situation
- ❑ Pain "just began"
- ❑ 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	_____	❑	❑	❑	❑
Allergist	_____	❑	❑	❑	❑
Chiropractor	_____	❑	❑	❑	❑
Dentist	_____	❑	❑	❑	❑
Ear, nose, throat	_____	❑	❑	❑	❑
Endocrinologist	_____	❑	❑	❑	❑
General practitioner	_____	❑	❑	❑	❑
Gynecologist/OB	_____	❑	❑	❑	❑
Internist	_____	❑	❑	❑	❑
Neurologist	_____	❑	❑	❑	❑
Neurosurgeon	_____	❑	❑	❑	❑
Nutritionist	_____	❑	❑	❑	❑
Opthalmologist	_____	❑	❑	❑	❑
Oral surgeon	_____	❑	❑	❑	❑
Orthodontist	_____	❑	❑	❑	❑
Orthopedist	_____	❑	❑	❑	❑
Osteopath	_____	❑	❑	❑	❑
Physical therapist	_____	❑	❑	❑	❑
Psychiatrist	_____	❑	❑	❑	❑
Psychologist	_____	❑	❑	❑	❑
Surgeon (general)	_____	❑	❑	❑	❑
Other _____	_____	❑	❑	❑	❑

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: _____

_____

_____

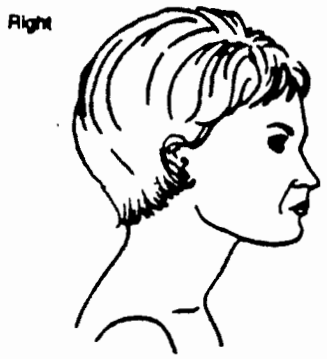
_____

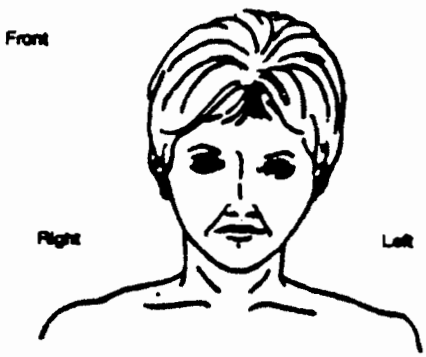
_____

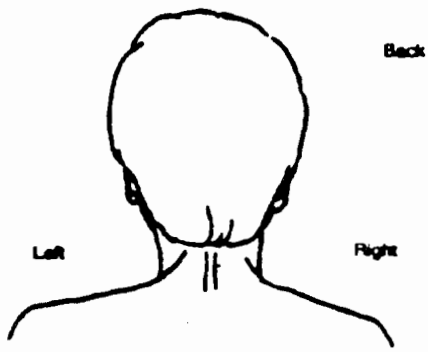
_____

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 ////////







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	2	3	4
Flickering	Jumping	Pricking	Sharp
Quivering	Flashing	Boring	Cutting
Pulsing	Shooting	Drilling	Lacerating
Throbbing		Stabbing	
Beating		Lancinating	
Pounding			

5	6	7	8
Pinching	Tugging	Hot	Tingling
Pressing	Pulling	Burning	Itchy
Gnawing	Wrenching	Scalding	Smarting
Cramping		Searing	Stinging
Crushing			

9	10	11	12
Dull	Tender	Tiring	Sickening
Sore	Taut	Exhausting	Suffocating
Hurting	Rasping		
Aching	Splitting		
Heavy			

13	14	15	16
Fearful	Punishing	Wretched	Annoying
Frightful	Gruelling	Blinding	Troublesome
Terrifying	Cruel		Miserable
	Vicious		Intense
	Killing		Unbearable

17	18	19	20
Spreading	Tight	Cool	Nagging
Radiating	Numb	Cold	Nauseating
Penetrating	Drawing	Freezing	Agonizing
Piercing	Squeezing		Dreadful
	Tearing		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) _____

PLEASE LIST ANY MEDICATION, FOOD, INHALED SUBSTANCE, OR ENVIRONMENTAL FACTOR THAT YOU MAY BE ALLERGIC TO:

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

DO YOU	YES	NO
Have a stressful situation at work?	☐	☐
Have a stressful situation at home?	☐	☐
Have a decreased desire for social activities?	☐	☐
Have little interest in doing things?	☐	☐
Feel lonely even with people?	☐	☐
Feel hopeless about the future?	☐	☐
Have a decreased appetite?	☐	☐
Have a loss of sexual interest or pleasure?	☐	☐
Feel low in energy or slowed down?	☐	☐
Feel easily annoyed or irritated?	☐	☐
Consider yourself to be a perfectionist?	☐	☐
See or have ever seen a psychiatrist, psychologist, or social worker?	☐	☐

If yes, please explain _____

SLEEPING HABITS: Do you	YES	NO
Sleep well at night?	☐	☐
Have trouble falling asleep?	☐	☐
Take medication/alcohol to fall asleep?	☐	☐
Wake up during the night?	☐	☐
Snore while sleeping?	☐	☐
Gasp for air in your sleep?	☐	☐
Mouth breathe while sleeping?	☐	☐
Clench your teeth at night?	☐	☐
Thrash your legs in your sleep?	☐	☐
Have a headache upon arising?	☐	☐
Feel exhausted upon arising?	☐	☐
Wake up too early in the morning?	☐	☐
Have stiff muscles in the morning?	☐	☐
Feel rested upon arising?	☐	☐
Have difficulty staying awake during the day?	☐	☐
Feel tired during the day?	☐	☐
Read or watch TV in bed?	☐	☐
Use two pillows?	☐	☐
Sleep on your stomach?	☐	☐

PLEASE NOTE HOW MUCH YOUR "CHIEF COMPLAINT" DISTURBS YOUR SLEEP BY CIRCLING THE NUMBER ON THE DIAGRAM:

0	1	2	3	4	5	6	7	8	9	10
No sleep										Completely prevents

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