# JED BERMAN, DDS, FAGD

Physical Health

Name_____Date_____

☐ Male ☐ Female Date of Birth_____

Name & address of physician_____

Have you been under a physician's care during the last two years?_____For_____

Have you been treated in a hospital in the last two years?_____For_____

Have you ever had major surgery?_____

If female: Are you taking hormones or birth control?_____Are you pregnant or nursing?_____

Are you now taking, or have you taken any medicines within the last year?_____

Please list_____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Any foods _____
☐ Other_____

Have you had or do you now have: ***(Please do not leave any blank)***

| | yes | no | | yes | no |
|---|---|---|---|---|---|
| Abnormal blood pressure | ☐ | ☐ | HIV positive | ☐ | ☐ |
| Allergy to latex | ☐ | ☐ | Herpes | ☐ | ☐ |
| Anemia | ☐ | ☐ | Jaundice | ☐ | ☐ |
| Angina | ☐ | ☐ | Kidney disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Liver disease | ☐ | ☐ |
| Artificial heart valves | ☐ | ☐ | Organ transplant | ☐ | ☐ |
| Asthma | ☐ | ☐ | Pacemaker | ☐ | ☐ |
| Cancer | ☐ | ☐ | Polio | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | Prolonged bleeding | ☐ | ☐ |
| Congenital heart lesions | ☐ | ☐ | Prolonged cough | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Prosthetic joint | ☐ | ☐ |
| Drug dependency | ☐ | ☐ | Psychiatric treatment | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Radiation therapy | ☐ | ☐ |
| Fainting | ☐ | ☐ | Rheumatic fever | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | Sickle cell anemia | ☐ | ☐ |
| Heart disease | ☐ | ☐ | Stroke | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | Thyroid problems | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| | | | Ulcers | ☐ | ☐ |

Do you have any disease, condition, or other problem not listed?_____

_____

_____

_____

The above information is true to the best of my knowledge, and if it changes, I will let Dr.Berman know prior to any further treatment. Signature_____

## Dental Health

When was your last dental visit?_____

How frequently did you see your dentist?_____

Are you having any dental problems that require immediate attention?_____

Do any of the following cause tooth discomfort? ☐ Hot ☐ Cold ☐ Chewing ☐ Sweets

How often do you brush your teeth?_____Floss?_____Other?_____

Do your gums bleed when you clean your teeth?_____

Do your gums ever feel tender or swollen?_____

Have you had periodontal treatment?_____When?_____

Do you clench or grind your teeth?_____

Do your jaws ever feel tired or ache?_____Click or pop?_____

Can you chew on both sides of your mouth?_____Comfortably?_____

Do you have frequent headaches?_____Earaches?_____

Have you ever had orthodontic treatment (braces)?_____When?_____

Do you lose or break fillings?_____

Do you usually have many cavities?_____

Do you have any loose teeth?_____Cracked or broken teeth?_____

Do you have noticeable wear on your teeth?_____Food traps?_____

Do you have any missing teeth?_____Have they been replaced?_____

If so, how? ☐ Fixed bridge ☐ Removeable partial ☐ Full denture ☐ Dental implant

Are you comfortable with the replacement?_____Please describe._____

_____

Have you ever wished you could change the appearance of your smile?_____

Have you ever had any cosmetic dentristry done to improve your appearance?_____

If so, are you pleased with the result?_____Please comment._____

_____

Have you ever had an unpleasant dental experience?_____

Please add anything you feel is important._____

_____