

PATIENT HEALTH HISTORY

For the office of Dr. Paul S. Sahni

Date _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work# _____ Cell# _____ E-mail _____

Height _____ ft. _____ in. Weight _____ lbs. **ALLERGIES TO MEDICATIONS:** _____

Occupation _____

Do you take a Pre-Medication before dental appointments? Yes / No If yes - please list pre-medication _____

Name of spouse (if applicable) _____ Phone # _____ - _____ - _____

Name of family member or friend to contact in case of an emergency (if other than spouse) _____

Relationship to patient _____ Phone # _____ - _____ - _____ Address _____

Name of person completing form (if other than patient) _____ Relationship to patient _____

All information provided on this form is for our records only and will be kept confidential. This information is vital to allow us to provide appropriate care for you.

Medical Information

Circle Y for YES, N for NO, or DK if you DON'T KNOW the answer to the questions.

Are you now under the care of a physician?.....**Y / N / DK**

Physician Name: _____ Phone: () _____

Address/City/State/Zip: _____

Are you in good health?.....**Y / N / DK**

Has there been any change in your general health within the past year?..... **Y / N / DK**

If yes, what condition(s) is/are being treated?

Date of last physical exam? _____

Have you ever had any serious illness, operation, or been hospitalized?.....**Y / N / DK**

If yes, what was the illness or problem?

Have you had a serious illness, operation, or been hospitalized in the **past 5 years?**.....**Y / N / DK**

If yes, what was the illness or problem?

Do you wear contact lenses? **Y / N / DK**

Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?..... **Y / N / DK**

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis, Paget's disease, or cancer? **Y / N / DK**

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? **Y / N / DK**

Date Treatment began: _____

Do you use Marijuana or Recreational Drugs?**Y / N / DK**

Do you use tobacco (smoking, snuff, chew, bidis)?**Y / N / DK**

If so, how interested are you in stopping?

(Circle One) **VERY / SOMEWHAT / NOT INTERESTED**

Do you drink alcoholic beverages?**Y / N / DK**

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

WOMEN ONLY Are you:

Pregnant?**Y / N / DK**

If Pregnant, number of weeks: _____

Nursing?**Y / N / DK**

Taking birth control pills or hormonal replacement?**Y / N / DK**

Joint Replacement – Have you had an orthopedic total joint (hip, shoulder, knee, elbow, finger) replacement? **Y / N / DK**

Date: _____ If yes, have you had any complications? _____

Does your physician recommend pre-medication (antibiotics) prior to your dental appointments?... **Y / N / DK** Medication Name: _____

Allergies – Are you allergic to or have you had a reaction to:

To all **YES** responses, specify type of reaction.

Local anesthetics _____ **Y / N / DK**

Aspirin _____ **Y / N / DK**

Penicillin or other antibiotics _____ **Y / N / DK**

Barbiturates, sedatives, or sleeping pills _____ **Y / N / DK**

Sulfa drugs _____ **Y / N / DK**

Codeine or other narcotics _____ **Y / N / DK**

Metals _____ **Y / N / DK**

Latex (rubber) _____ **Y / N / DK**

Iodine _____ **Y / N / DK**

Hay fever / seasonal _____ **Y / N / DK**

Animals _____ **Y / N / DK**

Food _____ **Y / N / DK**

Other _____ **Y / N / DK**

PATIENT HEALTH HISTORY (Cont.)

Circle Y for YES, N for NO, or DK if you DON'T KNOW the answer to the questions.

Heart Murmur	Y / N / DK	Abnormal bleeding	Y / N / DK	Sleep disorder	Y / N / DK
Mitral valve prolapse	Y / N / DK	Anemia	Y / N / DK	Mental health disorders ...	Y / N / DK
Artificial heart valves	Y / N / DK	Blood transfusion	Y / N / DK	Specify: _____	
Rheumatic fever	Y / N / DK	If yes, date: _____		Recurrent infections	Y / N / DK
Cardiovascular disease	Y / N / DK	Hemophilia	Y / N / DK	Type of infection: _____	
Angina	Y / N / DK	AIDS or HIV infection	Y / N / DK	Kidney problems	Y / N / DK
Arteriosclerosis	Y / N / DK	Ever tested positive for HIV virus.....	Y / N / DK	Night sweats	Y / N / DK
Congestive heart failure ..	Y / N / DK	Osteoporosis	Y / N / DK	Persistent swollen glands in neck	Y / N / DK
Ankle Swelling	Y / N / DK	Arthritis	Y / N / DK	Glaucoma	Y / N / DK
Coronary artery disease ...	Y / N / DK	Rheumatoid arthritis	Y / N / DK	Severe headaches / migraines	Y / N / DK
Damaged heart valves	Y / N / DK	Autoimmune disease	Y / N / DK	Sexually transmitted disease	Y / N / DK
Heart attack	Y / N / DK	Painful swollen joints	Y / N / DK	Specify: _____	
Low blood pressure	Y / N / DK	Systemic Lupus Erythematosus	Y / N / DK	Epilepsy	Y / N / DK
High blood pressure	Y / N / DK	Asthma	Y / N / DK	Fainting spells or seizures	Y / N / DK
Congenital heart defects ..	Y / N / DK	Bronchitis	Y / N / DK	Neurological disorders	Y / N / DK
Pacemaker	Y / N / DK	Emphysema	Y / N / DK	Specify: _____	
Rheumatic heart disease .	Y / N / DK	Sinus trouble	Y / N / DK	Chronic pain	Y / N / DK
Stroke	Y / N / DK	Tuberculosis	Y / N / DK	Thyroid problems	Y / N / DK
Short of breath	Y / N / DK	Eating disorder	Y / N / DK	Severe or rapid weight loss	Y / N / DK
Chest pain upon exertion .	Y / N / DK	Malnutrition	Y / N / DK	Cancer / Chemotherapy / Radiation Treatment	Y / N / DK
Persistent cough / Cough up blood	Y / N / DK	Stomach Ulcers	Y / N / DK	Regularly exposed to x-rays or other ionizing radiation	Y / N / DK
Skin rash or Hives	Y / N / DK	Gastrointestinal disease ...	Y / N / DK	Other: _____	
Diabetes	Y / N / DK	G.E. Reflux / persistent heart burn	Y / N / DK		
Specify: Type I or II		Hepatitis, jaundice or liver disease	Y / N / DK		
Excessive urination	Y / N / DK				
Thirsty much of time	Y / N / DK				
Dry Mouth	Y / N / DK				

Are you taking any of the following:

Antibiotics or sulfa drugs	Y / N / DK
Anticoagulants (blood thinners)	Y / N / DK
Medicine for high blood pressure	Y / N / DK
Cortisone (steroids)	Y / N / DK
Tranquilizers	Y / N / DK
Antihistamines	Y / N / DK
Aspirin	Y / N / DK
Ibuprofen / Tylenol	Y / N / DK
Insulin, Metformin, Glucophage, Orinase or similar drug	Y / N / DK
Digitalis	Y / N / DK
Nitroglycerin	Y / N / DK
Viagra or similar drugs	Y / N / DK
Oral Contraceptive or other hormonal therapy	Y / N / DK
Other	Y / N / DK

Are you taking or have you recently taken any prescription or over-the-counter medicine(s)?

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Do you have any disease, condition, or problem not listed above that you think we should know about?

If yes, explain _____

Chief Dental Complaint _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my endodontist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ Date: _____