Granite State Endodontics

Aneesa Al-Khalidi, D.M.D.
505 West Hollis Street, Suite 104
Nashua, NH 03062
(603) 883-3636 (ENDO)

HEALTH HISTORY

Date _____ Dr. Referral _____

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Work ( ) _____ Cell ( ) _____

Please circle Yes or No to the medical questions below:

(Your answers are for our records and will be considered confidential)

Are you in good health?	Yes	No
Have you had any serious illness or operation(s)?	Yes	No
Are you taking any of the following Medications? Please List: (**OR SUPPLY MED LIST**)		
Antibiotics? _____	Yes	No
Blood Thinners? _____	Yes	No
High Blood Pressure or Heart Medication? _____	Yes	No
Aspirin? _____	Yes	No
Pain Medication? _____	Yes	No
Are you, or have you recently been taking Cortisone or Steroids?	Yes	No
Are you taking any other medications not mentioned above?	Yes	No
(If yes, please list) _____		
Have you ever had Asthma?	Yes	No

Are you allergic to, or had adverse reactions from any of the following:

Local Anesthetics?	**Yes**	No
Latex?	**Yes**	No
Penicillin or any other Antibiotics? _____	**Yes**	No
Codeine or other Narcotics? _____	**Yes**	No
Aspirin? _____	**Yes**	No

Are you allergic to any other medications? (If yes, please describe.)

_____

Have you ever suffered from Drug Addiction?	Yes	No
Have you ever had Rheumatic Fever, Heart Murmur or Mitral Valve Prolapse?	Yes	No
Do you need to be Pre-Medicated? **(Heart issues or Joint replacements)** **	Yes	No
Have you ever had Heart Disease or a Stroke?	Yes	No
Do you have an Artificial Joint Prosthesis?	Yes	No
Do you have a Pacemaker?	Yes	No
Do you Have Sinus problems?	Yes	No
Do you have T.M.J. problems? (jaw joint disorder)	Yes	No

CONTINUED ON BACK

Do you have Diabetes?	Yes	No
If yes, do you take Insulin? _____	Yes	No
Have you ever had Hepatitis? (If yes what type) _____	Yes	No
Have you ever had Jaundice or Liver Disease?	Yes	No
Do you have Arthritis?	Yes	No
Do you suffer from Stomach Ulcers?	Yes	No
Do you have Kidney Disorders?	Yes	No
Do you have Thyroid problems?	Yes	No
Have you ever had Radiation or Chemotherapy? (When)_____	Yes	No
Are you taking or scheduled to begin taking Bisphosphonate medication? Ex: Fosamax, Actonel, Boniva or Aredia?	Yes	No
Since 2001, were you treated or are you presently scheduled to begin treatment with intravenous bisphosphonates for skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	Yes	No

If yes, please explain _____

_____

Do you have Colitis?	Yes	No
Have you ever had Tuberculosis?	Yes	No
Are you HIV positive, or do you have AIDS?	Yes	No
Do you have Bleeding Problems or Blood Disorders?	Yes	No
Do you have any disease, condition or problems not listed above?	Yes	No

(If yes, please explain.) _____

Name Primary Care Physician_____Tel # ( ) _____ Last Physical_____

** **Patient Signature** (Or Guardian's) _____ **Date**_____

****

Doctor's Signature _____ Date _____

Doctor's Notes: _____

Women Only

Are you taking oral contraceptives?	Yes	No
Are you pregnant? (If yes, how many weeks?) _____	Yes	No
Are you nursing?	Yes	No

** **NOTE:** *Patients taking birth control pills who are prescribed antibiotics should use another method of birth control for the remainder of the cycle. Initial:* _____