

1. History Taking: Slide 1

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2. 4 Year Medicine Program Overview

## 4 Year Medicine Program Overview

*Year 01: 2 Credits, 2 Exams*

Each exam contributes 50% towards the final grade

Medicine I:

- History Taking & Physical Examination:  
Medical, Dental & Pathological Assessment: Didactic & Axium
- Behavioral Medicine
- The Special Needs Patient: Domestic Violence: DV & IPV  
Disabilities
- Highest Priority Illnesses: Symptoms, Signs & Lab. Tests
- Pharmacology: Anesthetics, Analgesics, Antibiotics (AAAs)
- Prescription Writing

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3. 4 Year Medicine Program Overview

## 4 Year Medicine Program Overview

*Year '02: 3 Credits, 2 Courses*

Medicine II A:

- Medicine Lecture Series(MLS)  
2 exams, each exam is 30% of the final grade

Medicine II B:

- Management of The Medically Compromised Dental Patient: Do's Don'ts & DDIs  
1 Exam, 40% of final grade

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4. 4 Year Medicine Program Overview

## 4 Year Medicine Program Overview

*Year '03*

- 3 Credit Course
- Medicine III:
- Hospital Clerkship Program
  - 30 Rotations, 4 days /week for 5 weeks

*Year '04*

- Interdisciplinary Case Based Seminars
- No grades

*Year '03 & '04*

- Medical Consultations for Medically Compromised Patients (MCP Patients) getting treated in the TUSDM Clinics

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Medicine Year 01

## Medicine Year '01

### History Taking and Physical Examination: Medical & Dental Assessment

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Goals and Objectives

## Goals and Objectives

- Medical / Dental History & Physical Exam on a "Normal" and "Special Needs" patient
- Basic knowledge of the "*Highest Priority*" illnesses and their associated symptoms and signs
- Basic understanding of common Lab. Tests
- To have a thorough knowledge of Antibiotics and a working knowledge of Anesthetics, Analgesics
- Ability to write a Prescription for Analgesics, Antibiotics, Antifungals etc.

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## 7. Patient Management Tools

# Patient Management Tools

- History Taking
- Physical Examination
- Differential Diagnosis
- Laboratory Tests assessments
- Definitive Diagnosis
- Treatment Planning
- Deviations in Dental Management of a Medically Compromised Patient (MCP): AAAs

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## 8. Patient Interview: Practical Pointers

# Patient Interview: Practical Pointers

- It is the first step in the diagnostic workup
- The Doctor-Patient relationship is established at this time
- Be Neat, Professional, Respectful and Courteous
- Be culturally sensitive
- Introduce yourself and refer to the patient as "Mr. John Doe"
- Would the patient like you using his first name?

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9. Patient Interview: Practical Pointers

## Patient Interview: Practical Pointers

- Be interested & attentive to your patient during the interview
- Do not be distracted by your surroundings
- Interrogate sparingly, to aid a communicating patient or restrict rambling
- Gain your patient's trust
- Be CONFIDENTIAL
- Always inform the patient **prior** to starting the Physical Examination

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10. Patient Assessment Structure

## Patient Assessment Structure

- History Taking and Physical Examination:  
Each has a structure
- This structure is universal
- This structure is followed in any type of patient assessment: Dentistry, Medicine or Surgery
- This structure is incorporated into the TUSDM Electronic Medical Records (EMR) system - The Axiom Program

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11. History Taking Structure

## History Taking Structure

- Data Collection
- Chief Complaint
- Present History
- Past History
- Personal History
- Family History
- Review of Systems (ROS)
- Conclusion of History

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12. Physical Examination Structure

## Physical Examination Structure

- General appearance: Mental status
  - Neatness
  - Inter activeness
- Vital signs:
  - **Pulse**
  - **Respiration**
  - **Blood Pressure**
- Head and Neck Examination

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13. Physical Examination Structure, cont.

## Physical Examination Structure cont.

- Cranial Nerve Examination
- Examination of the Heart and Lungs
- Examination of the Extremities
- Musculoskeletal System Examination
- Neurological Examination
- Abdominal Examination

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14. History Taking: Detailed Discussion

## History Taking: Detailed Discussion

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15. History Taking: Data Collection

## History Taking: Data Collection

The basic information required for ALL patients:

Date of visit:.....Patient Record #:.....  
Name: (last).....(first).....(middle).....  
Home address:.....Home phone:.....  
Business Address:.....Business phone:.....  
Occupation:.....Emergency Contact:.....  
Date of birth:.....  
Sex: M / F:.....  
Marital status (S/M/D/W):.....  
Height:.....Weight:.....  
Referred by:.....PCP, Name & #:.....

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16. Data Collection: Details

## Data Collection: Details

Date of visit:

- For billing purposes
- To determine the frequency of care
- To schedule hygiene recall appointments

Patient Record #:

- To ID patients correctly, particularly those with similar names
- To maintain patient records in the file assigned to the patient
- To identify TUSDM Domestic Violence (DV) patients
- DV patients are de-identified in the TUSDM Axiom system

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17. Data: Name and Home Address

## Data: Name and Home Address

- Again, to correctly identify patients with similar names
- Dwelling Location :
- Is there a known disease prevalence at that location?  
eg: Hepatitis A
- How long has the patient lived at that location?
- Could the patient have moved from an endemic area?  
eg: Hepatitis E: Disease Translocation
- Is the dwelling a crowded environment?  
Communicable diseases occur more commonly: Strep.

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18. Data: Phone Numbers and Business Address

## Data: Phone #s and Business Address

Home phone:

- To contact the patient obviously!
- Always confirm that the patient can talk to you
- The patient may not have the privacy to communicate
- Never leave any patient health information on voicemail

Business Address:

- Helps in assessing occupation

Business phone:

- Confirm if its OK to call at work

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19. Data: Occupation and Emergency Contact

## Data: Occupation and Emergency Contact

Occupation:

- Certain occupations predispose to specific symptoms / diseases
- Waitressing can cause ankle swelling
- Carpentry can predispose to Naso-Pharyngeal Carcinoma
- Tire factory workers exposed to toxins can develop cirrhosis

Emergency Contact:

- Always establish the relationship with the patient
- Get the person's phone #
- Is contacted for patient information if in doubt
- If there is an emergency and the patient gets hospitalized

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20. Data: DOB and Gender

## Data: DOB and Gender

Date of birth:

- To correctly ID the patient
- To categorize the age bracket: Pediatric/ Adult/ Elderly

Sex: M / F:

- Transgender patients in "process of change" will be listed by their current gender
- Gender change occurs when the change is officially completed
- Some patients "in process" may wish for you to use their "alternate" name

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21. Data: Marital Status and Height/Weight

## Data: Marital Status and Height/Weight

Marital status (S/M/D/W):

- Monogamous?
- Anxiety? Depression? etc. in divorced or widowed
  
- Height & Weight:
- Lean? Obese?
- With weight loss confirm if it was planned or unplanned
- Eating disorders: Anorexia, Bulimia
- Needed to calculate drug dosages during a medical emergency
- H & W needed prior to the taking of radiographs

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22. Data: Referral and PCP

## Data: Referral and PCP

- Has the patient been referred by a Dentist / MD?

Primary Care Physician (PCP):

- Name Telephone # & Address  
When consultation is needed prior to Dentistry

Date of last visit?:

- To determine how current is the patient's information
- What was the Diagnosis during that visit?
- Were any Medications prescribed during that visit?

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23. Chief Complaint

## Chief Complaint

Described in the patient's own words the reason for seeking care:

*"I have a toothache"*

or

*"I need routine cleaning"*

or

*"I need a root canal"*

or

*"I just hadn't seen a dentist for some time"*

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24. Present History

## Present History

Describe in clear chronological order:

- The details of the problem affecting the patient: The What?
- When did the problem begin: The When?
- Where did the problem begin: The Where?
- What kinds of symptoms did the patient experience: The How?
- Has the patient taken any treatment for the problem
- Has treatment had any effect on the patient
- Has the problem affected the patient's routine lifestyle

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## Past History

# Past History

- Evaluation of the Past History gives you an insight about the health status of the patient up until now
- What diseases have affected the patient in the past?
- The childhood illnesses and highest priority illnesses are assessed
- Disease presence or absence is determined by eliciting the associated symptoms and signs

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## Past History

# Past History

The following Diseases / Facts are assessed:

- Anemia
- Bleeding disorders
- Cardio-respiratory disorders
- Drugs/medications
- Endocrine Disorders
- Fits and Faints
- Gastrointestinal Disorders
- Hospital Admissions
- Infectious Diseases

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Past History

## Past History

- Jaundice or liver disease
- Kidney disorders
- Likelihood of pregnancy
- Musculoskeletal disorders
- Neurological disorders
- Obstetric and gynecological disorders

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Past History

## Past History

- Psychiatric disease
- Radiation therapy
- Skin disorders
- Tetanus immunization/hepatitis immunization/influenza immunization
- Wound healing

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## Personal History

# Personal History

In this part of the history you get an insight into the patient's lifestyle, occupation, and habits

- What constitutes relaxation or recreation?
- What kind of job does the patient have? Is there stress?
- Is there any history of (H/O) alcohol intake?- How much?
- Any H/O weight change: Gain or Loss?  
Has the patient tried losing weight, if weight loss
- Is there any history of smoking cigarettes or using "recreational" drugs?- How much?

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## Personal History, cont.

# Personal History, cont.

- Any H/O coffee/tea intake? How much?
- Any history of diarrhea or vomiting?
- Is there any exposure to: Infectious diseases (Hepatitis; HIV/AIDS)  
Sexually Transmitted Diseases (STDs) ?
- Were the STDs treated?
- Does the patient use any: Herbal medications  
Over-the-counter (OTC) medications like  
Diet pills, Laxatives, Analgesics, cough/cold meds?  
Oral Contraceptives (OCs)  
Corticosteroids

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31. Family History

## Family History

- Evaluation of Family History determines the health of the immediate family members
- How old are the parents?  
If deceased, at what age and what was the cause of death?
- Health status of the siblings?  
If deceased, then determine cause of death and age at death
- Health status of the children?
- Establish disease prevalence in the family and age of onset
- ALWAYS DETERMINE IF THE PATIENT HAS THE DISEASES AFFECTING HIS / HER FAMILY

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32. Review of systems (ROS)

## Review of systems (ROS)

- In this portion of the history, all organ systems not already discussed during the interview are systematically reviewed
- It provides a thorough search for further not yet established or forgotten or accidentally omitted disease state / states

Following is the list of systems reviewed:

- Constitutional: Weight change
- Skin: Acute or chronic skin lesions
- Head: Headaches; seizures; injury; fainting etc

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33. Review of systems (ROS), cont.

## Review of systems (ROS), cont.

- Eyes: Vision; glaucoma; halos; irritation etc.
- Ears: Hearing; tinnitus; discharge/ pain
- Lymph Glands: Acute/ chronic?  
Shape, size, mobility, tender or painless?
- Respiratory System: Sinuses  
Lungs  
Hemoptysis (blood in the sputum)?
- Cardiovascular System: RF; Murmurs;  
Angina; Myocardial Infarction (MI)  
Hypertension etc.
- Gastrointestinal (GI) System: Oral or GI diseases

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34. Review of systems (ROS), cont.

## Review of systems (ROS), cont.

- Genitourinary: H/O Polyuria; nocturia; dysuria  
UTIs; renal stones etc.
- Menstrual History: Date of Last Menstrual Period (LMP)  
Oral Contraceptives (OCs)  
Pregnancies  
Menorrhagia (heavy periods)  
Metrorrhagia (frequent periods)
- Musculoskeletal System: Rheumatoid Arthritis (RA)  
Osteo Arthritis (OA)  
Gout  
Systemic Lupus Erythematosus (SLE)
- Endocrine System: DM; Thyroid or adrenal conditions
- Nervous System: Anxiety; Depression  
Transient Ischemic Attacks (TIA)  
Strokes / Cerebro Vascular Accidents (CVA), etc.

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35.

## Concluding the History

# Concluding the History

- It is the culmination of the History Taking process
- It constitutes the relevant data collected during history taking
- All the positive findings are logged and a logical framework of the case is constructed

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36.

## Personal History

# Personal History

In this part of the history you get an insight into the patient's lifestyle, occupation, and habits

- What constitutes relaxation or recreation?
- What kind of job does the patient have? Is there stress?
- Is there any history of (H/O) alcohol intake?- How much?
- Any H/O weight change: Gain or Loss?  
If yes for weight loss: Has the patient tried losing weight?
- Any H/O smoking cigarettes or using "recreational" drugs?- How much?

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37. Personal History, cont.

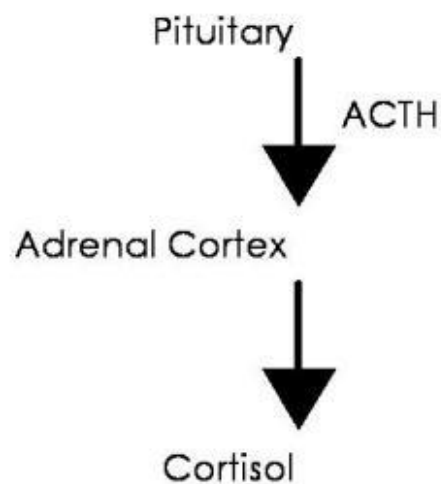
## Personal History, cont.

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Diet pills, Laxatives, Analgesics, cough/cold meds?  
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Corticosteroids

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38. Adrenal Cortex: Normal Endogenous Secretion

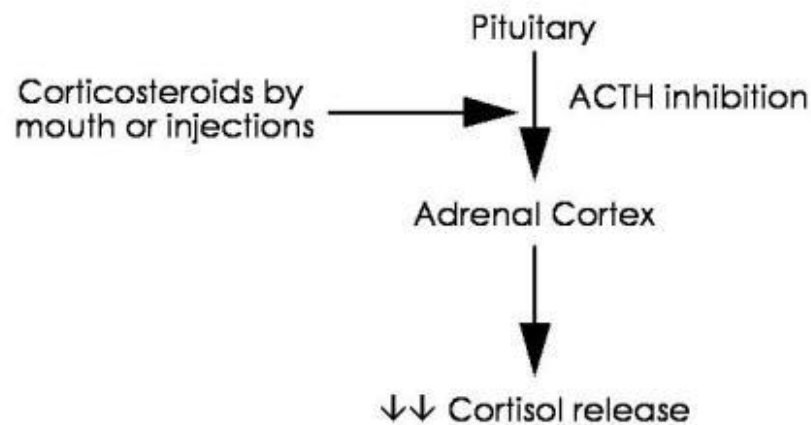
## Adrenal Cortex: Normal Endogenous Secretion



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39. Cortisol: Suppressed Endogenous Secretions

## Cortisol: Suppressed Endogenous Secretions



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40. Cortisol: Facts

## Cortisol: Facts

- Cortisol is secreted by the Adrenal cortex around 2-3 am every morning
- Cortisol is a Glucocorticoid: A stress fighting hormone
- Cortisol helps respond to stress caused by:
  - Infection
  - Inflammation
  - Bleeding
  - Trauma / Surgery
  - Intense Fear

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41. Steroid Facts: Normal Physiological Response

## Steroid Facts: Normal Physiological Response

The amount of Cortisol released daily is:

- 5 mg Prednisone equivalent
- Extra Cortisol is released in response to the stresses mentioned

The maximum amount of Cortisol released during stress is:

- 60 mg Prednisone equivalent
- The 2 Steroid Preparations used during Dentistry:
- Prednisone or Hydro Cortisone Sodium Succinate

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42. Cortisol: Facts

## Cortisol: Facts

- Steroids are prescribed for: acute / chronic inflammation

Endogenous Steroid Release:

- IS affected by Exogenous Steroids given by mouth (PO) or injections (IV/IM)
- Is NOT affected by Inhaled Steroids or Intra articular (intra joint) injections

Once the exogenous intake is stopped:

- It can take 2 months - 2 years for endogenous supply to normalize

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43. Steroid: Facts

## Steroid: Facts

Prior to major surgery you need to consult with the patient's MD:

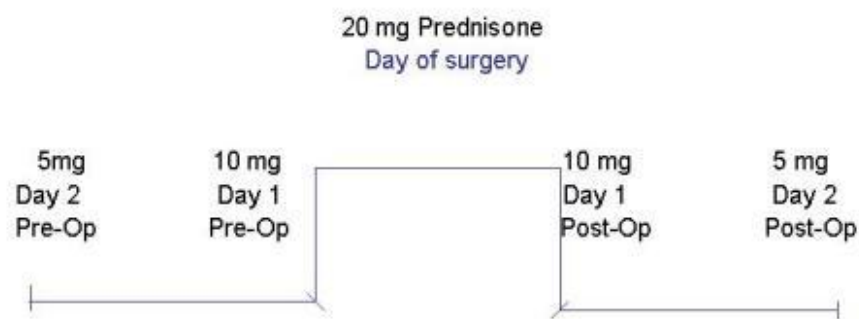
- To confirm the Steroid dose needed on the day of surgery
- The "Step Up & Step Down" Protocol of Steroid intake
- Sudden withdrawal can cause life threatening BP and blood sugar drop
  
- For planned procedures:
  - Steroid dose is gradually increased to the operative day dose, over a 48 hours pre-op period
  - Following surgery the Steroid dose is gradually decreased over a 48 hours period, post op

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44. Planned Steroid Boost Protocol

## Planned Steroid Boost Protocol

- Start the dose increase 48 hours pre op and reach the baseline intake 48 hours post op



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45.

## Personal History Questioning

# Personal History Questioning

Ask the patient the following questions during Personal History:

- Is there any H/O taking Steroids by mouth or by injections?
- Have you taken Steroids for 2 weeks / longer within the past 2 years?

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