

Eaglesoft Medical History(Copy)(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes
Have you ever been hospitalized or had a major operation? Yes No If yes
Have you ever had a serious head or neck injury? Yes No If yes
Are you taking any medications, pills, or drugs? Yes No If yes
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes
Are you on a special diet? Yes No
Do you use tobacco? Yes No
Do you use controlled substances? Yes No If yes
Are you required to premedicate? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No
Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No
Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes No
Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes No
Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes No
Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No
Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Yes No Shingles Yes No
Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No
Asthma Yes No Fainting Spells/Dizziness Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No
Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No
Breathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No
Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes No
Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes No
Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes No
Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Yes No
Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No
Yellow Jaundice Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: X Date: _____