Eaglesoft Medical History

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions. Are you under a physician's care now? If yes Yes No Have you ever been hospitalized or had a major operation? O Yes O 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? O Yes O 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 Yes No If yes medications containing bisphosphonates? Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? If yes 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 Yes No Hepatitis A Yes No Recent Weight Loss Yes No Hepatitis B or C Renal Dialysis Anaphylaxis Drug Addiction Yes No Yes No Yes No Yes No Yes No Anemia Yes No Easily Winded Yes No Herpes Rheumatic Fever Yes No Angina Yes No Emphysema Yes No High Blood Pressure Yes No Rheumatism Yes No High Cholesterol Scarlet Fever Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No Yes No Yes No Artificial Heart Valve Yes No Excessive Bleeding Yes No Hives or Rash Shingles Yes No Sickle Cell Disease Artificial Joint Yes
No Excessive Thirst Yes No Hypoglycemia Yes No Yes
No Irregular Heartbeat Asthma Fainting Spells/Dizziness Yes No Sinus Trouble Yes No Yes No Yes No **Blood Disease** Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No Stomach/Intestinal Disease Blood Transfusion Yes No Frequent Diarrhea Yes No Yes No Yes No Breathing Problems Yes No Frequent Headaches Yes No Yes No Liver Disease Yes No Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes No Yes No Lung Disease Thyroid Disease Yes No Yes No Yes No Mitral Valve Prolapse Tonsillitis Chemotherapy Yes No Hay Fever Yes No Yes No Yes No Yes No Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis 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 Heart Trouble/Disease Yes No Psychiatric Care Venereal Disease Yes No Yes
No Yes No Yellow Jaundice Yes No Have you ever had any serious illness not listed above? If ves Yes No 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: