Eaglesoft Medical History2017(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

Question	Answer	If yes
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
Are you taking any medications, pills, drugs, supplements, or vitamins?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel, Prolia, or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Women: Are you...

- ☐ Pregnant?
- ☐ Nursing?
- ☐ Taking Birth Control (Pills, Patches, or
- ☐ Trying to get pregnant?

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?

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