Eaglesoft Medical History(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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you currently under the primary care of a Physician?	Yes No	If yes
Are you currently under the care of a Specialist?	Yes No	If yes
Have you ever had a serious head or neck injury, been hospitalized or had a major operation?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Are you currently taking a blood thinner?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Have you ever taken Phen-Fen or Redux?	Yes No	If yes
Have you ever taken a drug containing bisphosphonates (Fosamax, Boniva, Actonel)?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco?	Yes No	If yes

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 ever had, any of the following?

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

Have you ever had a 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:_____