Eaglesoft Medical History(Copy)(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, 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?	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	

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
☐ No Known Allergies

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	Rheumatic Fever Yes No	Angina Yes No	Emphysema Yes No
High Blood Pressure Yes No	Rheumatoid Arthritis 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	Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No
Stomach/Intestinal Disease Yes No	COPD Yes No	Frequent Headaches Yes No	Liver Disease Yes No
Stroke Yes No	Bruise Easily Yes No	Low Blood Pressure Yes No	Cancer Yes No
Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No	Chemotherapy Yes No
Mitral Valve Prolapse 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
Stomach Ulcers Yes No	Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No
Yellow Jaundice Yes No	Migraines Yes No		

Have you ever had any serious illness not listed 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:_____