

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

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 ☐ NoDo 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 AnestheticsOther? ☐

If yes

Do you use controlled substances? ☐ Yes ☐ No

If yes

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

AIDS/HIV Positive ☐ Yes ☐ NoAlzheimer's Disease ☐ Yes ☐ NoAnaphylaxis ☐ Yes ☐ NoAnemia ☐ Yes ☐ NoAngina ☐ Yes ☐ NoArthritis/Gout ☐ Yes ☐ NoArtificial Heart Valve ☐ Yes ☐ NoArtificial Joint ☐ Yes ☐ NoAsthma ☐ Yes ☐ NoBlood Disease ☐ Yes ☐ NoBlood Transfusion ☐ Yes ☐ NoBreathing Problems ☐ Yes ☐ NoBruise Easily ☐ Yes ☐ NoCancer ☐ Yes ☐ NoChemotherapy ☐ Yes ☐ NoChest Pains ☐ Yes ☐ NoCold Sores/Fever Blisters ☐ Yes ☐ NoCongenital Heart Disorder ☐ Yes ☐ NoConvulsions ☐ Yes ☐ NoCortisone Medicine ☐ Yes ☐ NoDiabetes ☐ Yes ☐ NoDrug Addiction ☐ Yes ☐ NoEasily Winded ☐ Yes ☐ NoEmphysema ☐ Yes ☐ NoEpilepsy or Seizures ☐ Yes ☐ NoExcessive Bleeding ☐ Yes ☐ NoExcessive Thirst ☐ Yes ☐ NoFainting Spells/Dizziness ☐ Yes ☐ NoFrequent Cough ☐ Yes ☐ NoFrequent Diarrhea ☐ Yes ☐ NoFrequent Headaches ☐ Yes ☐ NoGenital Herpes ☐ Yes ☐ NoGlaucoma ☐ Yes ☐ NoHay Fever ☐ Yes ☐ NoHeart Attack/Failure ☐ Yes ☐ NoHeart Murmur ☐ Yes ☐ NoHeart Pacemaker ☐ Yes ☐ NoHeart Trouble/Disease ☐ Yes ☐ NoHemophilia ☐ Yes ☐ NoHepatitis A ☐ Yes ☐ NoHepatitis B or C ☐ Yes ☐ NoHerpes ☐ Yes ☐ NoHigh Blood Pressure ☐ Yes ☐ NoHigh Cholesterol ☐ Yes ☐ NoHives or Rash ☐ Yes ☐ NoHypoglycemia ☐ Yes ☐ NoIrregular Heartbeat ☐ Yes ☐ NoKidney Problems ☐ Yes ☐ NoLeukemia ☐ Yes ☐ NoLiver Disease ☐ Yes ☐ NoLow Blood Pressure ☐ Yes ☐ NoLung Disease ☐ Yes ☐ NoMitral Valve Prolapse ☐ Yes ☐ NoOsteoporosis ☐ Yes ☐ NoPain in Jaw Joints ☐ Yes ☐ NoParathyroid Disease ☐ Yes ☐ NoPsychiatric Care ☐ Yes ☐ NoRadiation Treatments ☐ Yes ☐ NoRecent Weight Loss ☐ Yes ☐ NoRenal Dialysis ☐ Yes ☐ NoRheumatic Fever ☐ Yes ☐ NoRheumatism ☐ Yes ☐ NoScarlet Fever ☐ Yes ☐ NoShingles ☐ Yes ☐ NoSickle Cell Disease ☐ Yes ☐ NoSinus Trouble ☐ Yes ☐ NoSpina Bifida ☐ Yes ☐ NoStomach/Intestinal Disease ☐ Yes ☐ NoStroke ☐ Yes ☐ NoSwelling of Limbs ☐ Yes ☐ NoThyroid Disease ☐ Yes ☐ NoTonsillitis ☐ Yes ☐ NoTuberculosis ☐ Yes ☐ NoTumors or Growths ☐ Yes ☐ NoUlcers ☐ Yes ☐ NoVenereal Disease ☐ Yes ☐ NoYellow Jaundice ☐ Yes ☐ NoHave 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: _____