

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 under a physician's care now?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever been hospitalized or had a major operation?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever had a serious head or neck injury?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Are you taking any medications, pills, or drugs?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input checked="" type="radio"/> Yes <input type="radio"/> No	If yes <input type="text"/>
Are you on a special diet?	<input checked="" type="radio"/> Yes <input type="radio"/> No	
Do you use tobacco?	<input checked="" type="radio"/> Yes <input type="radio"/> 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

Do you use controlled substances?

☒ Yes ☐ NoIf yes

Other?

☐If yes

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

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

Have you ever had any serious illness not listed

☒ Yes ☐ NoIf 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: _____