# 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

| | | |
|---|---|---|
| Who is your primary care physician? | ☐ | If yes |
| Have you ever been hospitalized or had a major operation? | ○ 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 had a serious head or neck injury? | ○ 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 |

| | | |
|---|---|---|
| Do you use controlled substances? | ○ Yes ○ No | If yes |
| Other? | ☐ | If yes |

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive ○ Yes ○ No | Alcohol Addiction ○ Yes ○ No | Alzheimer's Disease/Dementia ○ Yes ○ No | Anaphylaxis ○ Yes ○ No |
| Anemia ○ Yes ○ No | Angina ○ Yes ○ No | Anxiety ○ Yes ○ No | Artificial Heart Valve ○ Yes ○ No |
| Artificial Joint ○ Yes ○ No | Arthritis ○ Yes ○ No | Asthma ○ Yes ○ No | Cancer ○ Yes ○ No |
| Chemotherapy ○ Yes ○ No | Cold Sores/Fever Blister ○ Yes ○ No | Colitis ○ Yes ○ No | Congenital Heart Disorder ○ Yes ○ No |
| COPD ○ Yes ○ No | Depression ○ Yes ○ No | Diabetes ○ Yes ○ No | Dizziness/Vertigo ○ Yes ○ No |
| Easily Winded ○ Yes ○ No | Emphysema ○ Yes ○ No | Epilepsy ○ Yes ○ No | Excessive Bleeding ○ Yes ○ No |
| Excessive Thirst ○ Yes ○ No | Frequent Cough ○ Yes ○ No | Frequent Diarrhea ○ Yes ○ No | Frequent Headaches ○ Yes ○ No |
| Fibromyalgia ○ Yes ○ No | Glaucoma ○ Yes ○ No | Gout ○ Yes ○ No | Heart Attack ○ Yes ○ No |
| Heart Murmur ○ Yes ○ No | Heart Pacemaker ○ Yes ○ No | Heart Trouble/Disease ○ 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 ○ Yes ○ No | Hypoglycemia ○ Yes ○ No | Irregular Heartbeat ○ Yes ○ No |
| Kidney Problems ○ Yes ○ No | Kidney Stones ○ Yes ○ No | Leukemia ○ Yes ○ No | Liver Disease ○ Yes ○ No |
| Low Blood Pressure ○ Yes ○ No | Lupus ○ Yes ○ No | Mitral Valve Prolapse ○ Yes ○ No | Osteoporosis ○ Yes ○ No |
| Pain in Jaw Joints ○ Yes ○ No | Psychiatric Treatment ○ Yes ○ No | Radiation Treatments ○ Yes ○ No | Recent Weight Loss ○ Yes ○ No |
| Renal Dialysis ○ Yes ○ No | Rheumatism ○ Yes ○ No | Rheumatic Fever ○ Yes ○ No | Scarlet Fever ○ Yes ○ No |
| Seasonal Allergies ○ Yes ○ No | Seizures ○ Yes ○ No | Shingles ○ Yes ○ No | Sickle Cell Disease ○ Yes ○ No |
| Sinus Trouble ○ Yes ○ No | Sleep Apnea ○ Yes ○ No | Spina Bifida ○ Yes ○ No | Stomach/Acid Reflux ○ Yes ○ No |
| Stroke ○ Yes ○ No | Substance Abuse ○ Yes ○ No | Swelling of Limbs ○ Yes ○ No | Thyroid Problems ○ Yes ○ No |
| Tuberculosis ○ Yes ○ No | Tumors or Growths ○ Yes ○ No | Ulcers ○ 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:_____