Eaglesoft Medical History Birth Date:

Patient Name:

X

Date Created:

Date:_____

though dental personnel pr	imarily trea	at the are	ea in and around y	our mou	th, your mo	uth is a pa	rt of your entire body. He	alth problems	s that yo	u may have, or medication that	you may	be tak
re 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?					⊚ No	If yes						
Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other					⊚ No	If yes						
					◎ No	If yes						
					⊚ No	If yes						
edications containing bisph				O ICS	0110	,						
Are you on a special diet? Do you use tobacco?					○ No							
					○ No							
o you use controlled substa	ances?			Yes	⊚ No	If yes						
men: Are you			_	_								
Pregnant/Trying to get p	regnant?			Nursin	ng?			Та	king oral	contraceptives?		
you allergic to any of the	followina?											
Aspirin			Penicillin				Codeine			Acrylic		
Metal			Latex				Sulfa Drugs			Local Anesthetics		
ther?						If yes						
						,						
you have, or have you had IDS/HIV Positive			ng? Cortisone Medici	10	@ V	€ Ne	Hemophilia			Radiation Treatments	@ v	@ N
IDS/HIV Positive Izheimer's Disease	⊚ Yes			ie	⊚ Yes			O Yes			O Yes	
	O Yes		Diabetes Drug Addiction		⊚ Yes		Hepatitis A	O Yes		Recent Weight Loss	O Yes	_
naphylaxis nemia	⊚ Yes		Drug Addiction		⊚ Yes		Hepatitis B or C	O Yes		Renal Dialysis Rheumatic Fever	O Yes	
	O Yes	_	Easily Winded Emphysema		⊚ Yes		Herpes High Blood Pressure	⊚ Yes		Rheumatism	O Yes	_
Angina Arthritis/Gout	O Yes		Epilepsy or Seizu		⊚ Yes		High Cholesterol	© Yes		Scarlet Fever	O Yes	
Artificial Heart Valve	O Yes		Excessive Bleedi		⊚ Yes		Hives or Rash	O Yes		Shingles	O Yes	
Artificial Joint	Yes		Excessive Thirst	ig	⊚ Yes		Hypoglycemia	© Yes		Sickle Cell Disease	O Yes	
Asthma	Yes			zzinecc	⊚ Yes		Irregular Heartbeat	O Yes		Sinus Trouble	O Yes	
Blood Disease	Yes		Fainting Spells/D Frequent Cough	ZZINESS	⊚ Yes		Kidney Problems	O Yes		Spina Bifida	O Yes	
Blood Transfusion	Yes		Frequent Diarrhe		⊚ Yes		Leukemia	O Yes		Stomach/Intestinal Disease	O Yes	
Breathing Problems	O Yes		Frequent Heada		⊚ Yes		Liver Disease	© Yes		Stroke Stroke	O Yes	
Bruise Easily	YesYes		Genital Herpes	lies	YesYes		Low Blood Pressure	O Yes		Swelling of Limbs	O Yes	_
Cancer	Yes		Glaucoma		© Yes		Lung Disease	Yes Yes		Thyroid Disease	YesYes	
Chemotherapy	© Yes		Hay Fever		© Yes		Mitral Valve Prolapse	© Yes		Tonsillitis	© Yes	_
Chest Pains	Yes		Heart Attack/Fai	ure		◎ No	Osteoporosis	© Yes		Tuberculosis	© Yes	
Cold Sores/Fever Blisters	© Yes		Heart Murmur		© Yes		Pain in Jaw Joints	© Yes		Tumors or Growths	© Yes	
Congenital Heart Disorder	© Yes		Heart Pacemake			⊚ No	Parathyroid Disease	© Yes		Ulcers	© Yes	_
Convulsions	© Yes		Heart Trouble/Di			⊚ No	Psychiatric Care	© Yes		Venereal Disease	© Yes	_
	0	· · · ·	·		0.11			0.11	· · ·	Yellow Jaundice	Yes	_
ave you ever had any serio	ous illness r	not listed	above?	Yes	No No	If yes				<u> </u>		
				a	J.110	/03						
mments:												
					ly answered	l. I unders	stand that provid <mark>i</mark> ng incorre	ect informatio	n can be	dangerous to my (or patient's)	health.	It is m
	1 60											
nsibility to inform the dent	al office of	any cha	nges in medical sta	tus.								
onsibility to inform the dent nature of Patient, Parent o			nges in medical sta	tus.								