Eaglesoft Medical History-UPDATED 9/13/17

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, c

Do you have a general physician?	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
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	
Do you use controlled substances?	Yes No	If yes

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

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/Dementia 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	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis 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	Breathing Problems Yes No
Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No	Bruise Easily Yes No
Low Blood Pressure Yes No	Swelling of Limbs Yes No	Cancer Yes No	Glaucoma Yes No
Lung Disease Yes No	Thyroid Disease Yes No	Chemotherapy Yes No	Hay Fever Yes No
Mitral Valve Prolapse Yes No	Tonsillitis 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	Ulcers Yes No	Convulsions Yes No	Heart Trouble/Disease Yes No
Psychiatric Care Yes No	Yellow Jaundice Yes No	Acid Reflux/GERD Yes No	

Have you ever had any serious illness not listed above? 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:_____