Medical History

Eaglesoft Medical History

Patient First Name: _____ Patient Last Name: _____ Date Created: _____ Birth Date: _____

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,

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
○ No
If yes

Do you use tobacco ?
○ Yes
○ No
If yes

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
☐ Metal
☐ Acrylic
☐ Penicillin
☐ Latex
☐ Codeine
☐ Sulfa Drugs
☐ Local Anesthetics
☐ Other?
If yes _____

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

	Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐

Have you ever had any serious illness not listed above?
○ Yes
○ No
If yes

Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐
Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐
Chest Pains	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐
Cold Sores/ Fever Blisters	☐	☐	Heart Pacemaker	☐	☐	Pain in Jaw Points	☐	☐
Congenital Heart Disorder	☐	☐	Heart Trouble/Disease	☐	☐	Parathyroid Disease	☐	☐
Convulsions	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐
Radiation Treatments	☐	☐	Recent Weight Loss	☐	☐	Renal Dialysis	☐	☐
Rheumatic Fever	☐	☐	Rheumatism	☐	☐	Scarlet Fever	☐	☐
Shingles	☐	☐	Sickle Cell Disease	☐	☐	Sinus Trouble	☐	☐
Spina Bifida	☐	☐	Stomach/Intestinal Disease	☐	☐	Stroke	☐	☐
Swelling of Limbs	☐	☐	Thyroid Disease	☐	☐	Tonsillitis	☐	☐
Tuberculosis	☐	☐	Tumors or Growths	☐	☐	Ulcers	☐	☐
Venereal Disease	☐	☐	Yellow Jaundice	☐	☐			

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

Sign

Date: