## Eaglesoft Medical History Birth Date:

Patient Name:

Date Created:

Date 2/25/2016

Although dental personr medication that you may	nel primarily treat y be taking, could	the area in and around the large in the larg	your mouth, you rrelationship witl	ir mouth is a part of your on the dentistry you will rec	entire body. Heal ceive. Thank you	th problems that you may for answering the following	have, or g questions.
Are you under a physician's care now?			○ No If y	es			
Have you ever been hospitalized or had a major operation?			○ No If y	es			
Have you ever had a serious head or neck injury?			○ No If y	es			
Are you taking any medications, pills, or drugs?			○ No If y	es			
Do you take, or have you taken, Phen-Fen or Redux?			O No If y				
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Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			○ No If y	es			
Are you on a special diet?			O No				
Do you use tobacco?							
Women: Are you							
☐ Pregnant/Trying to g	get pregnant?	☐ Nursin	g?		☐ Taking or	al contraceptives?	
Are you allergic to any of	the following?	Denisillia		Codeine		Acrylic	
☐ Aspirin ☐ Penicillin ☐ Metal ☐ Latex		Latex		Sulfa Drugs		Local Anesthetics	
Metal		Ediex		sund brugs		E Local Allestrictics	
Do you use controlled substances?			○ No If y	es			
Other?			If y	es			
Do you have, or have you	had any of the	following?					
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's Disease	O Yes O No	Diabetes	O Yes O No		O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No		O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No		O Yes O No	Rheumatic Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No		O Yes O No	Rheumatism	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No		O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No		O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No		O Yes O No	Sickle Cell Disease	O Yes O No
	O Yes O No	Fainting Spells/Dizzines		, pog., coa	O Yes O No		O Yes O No
Asthma			O Yes O No	_	O Yes O No	Sinus Trouble	Yes No
Blood Disease	O Yes O No	Frequent Cough		,		Spina Bifida	
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No		O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No		O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes	O Yes O No		O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma	O Yes O No		O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Hay Fever	O Yes O No	The second second	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure	O Yes O No		O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters		Heart Murmur	O Yes O No		O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder		Heart Pacemaker	O Yes O No	. d. di., i dia dibedde	Yes No	Ulcers	O Yes O No
Convulsions	O Yes O No	Heart Trouble/Disease	e O Yes O No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	O Yes O 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					Da	ate:	