

Eaglesoft Medical History (New Form - Use Me!)(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, c Thank you for answering the following questions.

Is there anything specific that brings you in today? If yes, please give a brief discription. Yes No If yes

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/vitamins/supplements/drugs? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Do you use tobacco? If yes, kind and frequency of use. Yes No If yes

Do you use controlled substances? Yes No If yes

Do you have acid reflux or persistant heartburn? Yes No If yes

Have you ever done a sleep study and/or been diagnosed with sleep apnea? Yes No If yes

Has anyone ever told you that you clench or grind your teeth? Yes No If yes

Do you wear any kind of appliance when you sleep? Yes No If yes

Women: are you currently

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, Alzheimer's Disease, Anaphylaxis, Anemia, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Yellow Jaundice, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Decreased Energy, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Trouble Sleeping, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problems, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, HPV

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

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: _____