Eaglesoft Medical History Feb 2015

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following

Do you have a Primary Care Physician?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever taken oral or IV medication for osteoporosis?	○ Yes ○ No	If yes
Do you use contolled substances?	○ Yes ○ No	If yes

Do you use...

☐ Cigarettes ☐ Cigars/Pipes ☐ Chewing Tobacco ☐ e-Cigarettes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Please list any medications, pills, or supplements you are taking in the box below:

Are you allergic to any of the following?

Acrylic	○ Yes ○ No	Aspirin	○ Yes ○ No	Codeine	○ Yes ○ No	Erythromycin	○ Yes ○ No
Latex	○ Yes ○ No	Local Anesthetics	○ Yes ○ No	Metal	○ Yes ○ No	Penicillin/Amoxicillin	○ Yes ○ No
Seasonal Allergies	○ Yes ○ No	Sulfa	○ Yes ○ No	Tetracycline	○ Yes ○ No		

Do you have any other allergies? ○ Yes ○ No If yes

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

Acid Reflux/GERD	○ Yes ○ No	ADD/ADHD	○ Yes ○ No	AIDS/HIV	○ Yes ○ No	Alcohol Dependency	○ Yes ○ No
Alzheimer's/Dementia	○ Yes ○ No	Anemia	○ Yes ○ No	Anxiety	○ Yes ○ No	Arthritis	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Asthma	○ Yes ○ No	Bipolar Disorder	○ Yes ○ No
Bleeding Disorder	○ Yes ○ No	Blood Pressure - High	○ Yes ○ No	Blood Pressure - Low	○ Yes ○ No	Cancer	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Cold Sores	○ Yes ○ No	COPD	○ Yes ○ No	Depression	○ Yes ○ No
Diabetes	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Heart Problem or Disease	○ Yes ○ No
Hepatitis	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Lung Disease	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Radiation Treatment	○ Yes ○ No	Schizophrenia	○ Yes ○ No
Seizures	○ Yes ○ No	Sinus Trouble	○ Yes ○ No	Sleep Apnea	○ Yes ○ No	Stroke	○ Yes ○ No
Thyroid Problems	○ Yes ○ No	Tonsilitis	○ Yes ○ No	Tuberculosis	○ Yes ○ 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 Date:_____