

Eaglesoft Medical History 2/2018

Patient Name:

Birth Date:

Date Created:

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you under a physician's care now? Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Do you use tobacco?

Women: Are you...

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

Are you allergic to any of the following?

Aspirin Metal Penicillin Latex Codeine Sulfa Drugs Acrylic Local Anesthetics

Other Medical/Medicine Allergies? Do you use controlled substances?

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

AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problems Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Diabetes Drug Addiction Emphysema Epilepsy or Seizures Excessive Bleeding Fainting Spells/Dizziness Frequent Cough Frequent Headaches Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints 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 Tuberculosis Tumors or Growths Ulcers *

Have you ever had any serious illness not listed

Comments

Empty text box for 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: _____