

Eaglesoft Medical History- 2015 Updated - 6/15/15

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 questions.

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 prescription medications or supplements?  Yes  No If yes [ ]
Do you require premedication for a medical  Yes  No If yes [ ]
Do you experience frequent headaches or grind your teeth often?  Yes  No If yes [ ]
Are you on a special diet?  Yes  No
Do you use tobacco or alcohol?  Yes  No

Women: Are you...

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

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic
 Any Metals  Latex  Sulfa Drugs  Local Anesthetics
 Iodine  Keflex

Are you allergic to anything other than what is listed above? If yes, please list.  Yes  No If yes [ ]

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

AIDS/HIV Positive  Yes  No Hemophilia  Yes  No Radiation Treatments  Yes  No Alzheimer's Disease  Yes  No
Diabetes  Yes  No Hepatitis A, B or C  Yes  No Recent Weight Loss  Yes  No Anaphylaxis  Yes  No
Drug Addiction  Yes  No Renal Dialysis  Yes  No Anemia  Yes  No Easily Winded  Yes  No
Herpes ( HPV, Thrush)  Yes  No Rheumatic Fever  Yes  No Angina  Yes  No Emphysema  Yes  No
High Blood Pressure  Yes  No Rheumatism  Yes  No Arthritis/Gout  Yes  No Epilepsy or Seizures  Yes  No
High Cholesterol  Yes  No Scarlet Fever  Yes  No Artificial Heart Valve  Yes  No Excessive Bleeding  Yes  No
Hives or Rash  Yes  No Shingles  Yes  No Artificial Joint  Yes  No Excessive Thirst  Yes  No
Hypoglycemia  Yes  No Sickle Cell Disease  Yes  No Asthma  Yes  No Fainting Spells/Dizziness  Yes  No
Irregular Heartbeat  Yes  No Sinus Trouble  Yes  No Blood Disease  Yes  No Frequent Cough  Yes  No
Kidney Problems  Yes  No Blood Transfusion  Yes  No Leukemia  Yes  No Stomach/Intestinal Disease  Yes  No
Breathing Problems  Yes  No Frequent Headaches  Yes  No Liver Disease  Yes  No Stroke  Yes  No
Bruise Easily  Yes  No Low Blood Pressure  Yes  No Cancer  Yes  No Lung Disease  Yes  No
Thyroid Conditions  Yes  No Chemotherapy  Yes  No Hay Fever  Yes  No Mitral Valve Prolapse  Yes  No
Chest Pains  Yes  No Heart Attack/Failure  Yes  No Osteoporosis  Yes  No Tuberculosis  Yes  No
Cold Sores/Fever Blisters  Yes  No Heart Murmur  Yes  No Tumors or Growths  Yes  No Congenital Heart Disorder  Yes  No
Heart Pacemaker  Yes  No Ulcers  Yes  No Convulsions  Yes  No Heart Trouble/Disease  Yes  No
Psychiatric Care  Yes  No Yellow Jaundice  Yes  No Organ Transplant  Yes  No Allergies ( seasonal/food)  Yes  No
Acid Reflux  Yes  No Anxiety/Depression  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: \_\_\_\_\_