Eaglesoft Medical History 2024

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

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, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get 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	Yes No	Radiation Treatments	Yes No	Sickle cell trait	Yes No	Hepatitis A	Yes No
Recent Weight Loss	Yes No	Running fever today	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No
Renal Dialysis	Yes No	Sickle Cell Disease	Yes No	Easily Winded	Yes No	Herpes	Yes No
Rheumatic Fever	Yes No	Angina	Yes No	Diabetes Type 1 or 2	Yes No	High Blood Pressure	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	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	Anemia	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	Spina Bifida	Yes No	Down's Syndrome	Yes No
Frequent Diarrhea	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
Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No
Asthma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No
Runing fever today	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No	HPV	Yes No
Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No
Ulcers	Yes No	Cerebral Palsy	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No
Venereal Disease	Yes No	Yellow Jaundice	Yes No	ADD/ADHD	Yes No	Autism or Autism Scale	Yes No

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:_____