Eaglesoft Medical History 2017(Copy)(Copy)(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

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
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Acrylic	☐ Latex
☐ Local Anesthetics	☐ Allergies	☐ Metal	

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

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

ADHD ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
AIDS/HIV Positive ◯ Yes ◯ No	Cold Sores/FeverBlisters ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Head/Neck ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Hepatitis_____ ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Allergies ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Special Diet ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Autism ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Back Problems ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Blood Thinners ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Remission ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No		

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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist iinsurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient, Parent or Guardian:

X Date:_____