Date 10/3/2023

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel p	rimarily treat the ar	ea in and around your mou	uth, your mo	uth is a pa	rt of your entire body. He	alth problems that y	ou may have, or medication tha	t you may be tak
Are you under a physician's care now?			○ No	If yes				
Have you ever been hospita	r operation? O Yes	○ No	If yes					
Have you ever had a serious	y? O Yes	○ No	If yes					
Are you taking any medication	O Yes	○ No	If yes					
Do you take, or have you ta		_	If yes					
Have you ever taken Fosam		○ No						
nedications containing bisph		or any other Yes	○ No	If yes				
Are you on a special diet?		O Yes	○ No					
o you use tobacco?	O Yes	○ No						
o you use controlled substa	O Yes	○ No	If yes					
omen: Are you								
Pregnant/Trying to get p	Nursi	ng?		☐ Taking oral contraceptives?				
e you allergic to any of the	following?							
Aspirin	Penicillin			Codeine		Acrylic		
Metal		Latex			Sulfa Drugs		Local Anesthetics	
ther?				If yes				
you have, or have you had	d, any of the follow	ing?						
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes	○ No	Hemophilia	O Yes O No	Radiation Treatments	O Yes O No
llzheimer's Disease	Yes No	Diabetes		O No	Hepatitis A	Yes No	Recent Weight Loss	O Yes O No
Anaphylaxis	Yes No	Drug Addiction	_	O No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded		○ No	Herpes	O Yes O No	Rheumatic Fever	O Yes O No
Angina	Yes No	Emphysema	O Yes	O No	High Blood Pressure	O Yes O No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures		○ No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding		○ No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst		○ No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	O Yes O No	Fainting Spells/Dizziness	_	○ No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	Yes No	Frequent Cough	_	○ No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea		○ No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	O Yes	O No	Liver Disease	O Yes O No	Stroke	Yes No
Pruise Easily	O Yes O No	Genital Herpes		○ No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	Yes No	Glaucoma		○ No	Lung Disease	O Yes O No	Thyroid Disease	Yes No
Chemotherapy	O Yes O No	Hay Fever		○ No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Heart Attack/Failure		○ No	Osteoporosis	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur		○ No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Congenital Heart Disorder	O Yes O No	Heart Pacemaker		○ No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Convulsions	Yes No	Heart Trouble/Disease	O Yes	○ No	Psychiatric Care	O Yes O No	Venereal Disease Yellow Jaundice	Yes No
ive you ever had any serio	ous illness not listed	labove? voc	○ No	If yes				
		Yes	○ No	11 yes				
mments:								
the best of my knowledge, t ponsibility to inform the den			ely answered	d. I unders	stand that providing incorre	ect information can b	pe dangerous to my (or patient's) health. It is m
ignature of Patient, Parent	or Guardian:					ı	Date:	