Eaglesoft Medical History(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Do you have a general physician/ primary care doctor? Who is it?	◯ Yes ◯ No	If yes
Have you had surgery or been hospitalized in the last 2 years?	◯ Yes ◯ No	If yes
Do you have Fluoride (city water) in your water at home?	◯ Yes ◯ No	If yes
Do you have a family history of Diabetes or Periodontal Disease?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates for Osteoporosis?	◯ Yes ◯ No	If yes
Do you need to pre-medicate with antibiotics prior to you dental appointments? If so, what antibiotic do you take?	◯ Yes ◯ No	If yes
Do you use tobacco or any controlled substances?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes

Do you have, or have you had Cancer? What kind?	◯ Yes ◯ No	If yes
Did you require Chemotherapy or Radiation treatment?	◯ Yes ◯ No	If yes

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other Antibiotics? ☐ Seasonal allergies

Other? ☐ If yes

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

A-fib / Irregular Heartbeat ◯ Yes ◯ No	Anaphylactic Allergic Reaction ◯ Yes ◯ No	Acid Reflux / Heartburn ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No
AIDS / HIV+ ◯ Yes ◯ No	Alcoholism / Drug Addiction ◯ Yes ◯ No	Anemia ◯ Yes ◯ No	Angina / Chest Pains ◯ Yes ◯ No
Anxiety / Depression ◯ Yes ◯ No		Autoimmune Disease ◯ Yes ◯ No	Blood Disease / Transfusion ◯ Yes ◯ No
Arthritis / Gout ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Eating Disorder ◯ Yes ◯ No	Epilepsy / Seizures ◯ Yes ◯ No
Excessive Dry Mouth ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Fainting Spells / Dizziness ◯ Yes ◯ No
Frequent Unexplained Cough ◯ Yes ◯ No	Excessive Snoring ◯ Yes ◯ No	Heart Trouble / Disease ◯ Yes ◯ No	Glaucoma / Eye Disease ◯ Yes ◯ No
Excessive Bleeding / Blood Thinner Medic ◯ Yes ◯ No	Frequent Headaches / Migraines ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No
Liver Disease ◯ Yes ◯ No	Herpes / Cold Sores / Fever Blisters ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Kidney Disease / Dialysis ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No
Recent Unexplained Weight Loss ◯ Yes ◯ No	High Blood Sugar / Pre-Diabetes ◯ Yes ◯ No	Sleep Apnea / CPAP Machine ◯ Yes ◯ No	Stomach / Intestinal Disease ◯ Yes ◯ No
Stomach / Intestinal Disease ◯ Yes ◯ No	Pain in Jaw Joints / TMJ Issues ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Thyroid Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No		

Artificial Heart Valve? When?	◯ Yes ◯ No	If yes
Heart Attack / Heart Failure / Hear Stents? When?	◯ Yes ◯ No	If yes
Artificial Joint? What joint? When?	◯ Yes ◯ No	If yes
Diabetic? What Type?	◯ Yes ◯ No	If yes
Hepatitis A, B, or C? What Type?	◯ Yes ◯ No	If yes
Mitral Valve Prolapse?	◯ Yes ◯ No	If yes
Rheumatic Fever / Scarlet Fever?	◯ Yes ◯ No	If yes
Heart Murmur? When was it diagnosed?	◯ Yes ◯ No	If yes
Heart Pacemaker? When was it placed?	◯ Yes ◯ No	If yes
Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes
Blood Pressure (we will fill in your blood pressure reading)		

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:_____