Eaglesoft Medical History 2(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, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Question			
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
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Have you ever had a serious head or neck injury?	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
Do you take blood thinners?	Yes	No	If yes
Do you require antibiotics prior to treatment?	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
- Tetracycline

Other? If yes

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

AIDS/HIV Positive	Yes	No	Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No
Drug Addiction	Yes	No	Anemia	Yes	No	Anaphylaxis	Yes	No	Angina	Yes	No
Emphysema	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	Artificial Joint	Yes	No
Hypoglycemia	Yes	No	Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No
Sinus Trouble	Yes	No	Kidney Problems	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	Glaucoma	Yes	No	Thyroid Disease	Yes	No	Hay Fever	Yes	No
Mitral Valve Prolapse	Yes	No	Tonsillitis	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
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Convulsions	Yes	No
Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	ADHD	Yes	No	Acid Reflux	Yes	No
Autism	Yes	No	Hepatitis C	Yes	No	Hepatitis B	Yes	No			

Have you ever had any serious illness not listed above? 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:__________