Eaglesoft Medical History Birth Date:

Patient Name:

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Date Created:

Date:____

taking, could have an import							may have, or medication that	you may be
Are you under a physician's	s care now?	O Yes	○ No	If yes				
Have you ever been hospitalized or had a major operation?			○ No	If yes				
Have you ever had a seriou	jury? O Yes	No No	If yes					
Are you taking any medications, pills, or drugs?			○ No	If yes				
Do you take, or have you taken, Phen-Fen or Redux?			○ No	If yes				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			○ No	If yes				
Are you on a special diet?	O Yes	O No						
Do you use tobacco?			○ No					
Do you use controlled substances?			No No	If yes				
Women: Are you								
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?								
Are you allergic to any of the	following?	Penicillin			Codeine		Acrylic	
Metal		Latex			Sulfa Drugs		Local Anesthetics	
Other?				If yes				
Do you have, or have you had	d, any of the follow	ing?						
AIDS/HIV Positive	O Yes O No	Cortisone Mediane	O Yes	O No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	O Yes	O No	Hepatitis A	Yes No	Recent WeightLoss	Yes No
Anaphylaxis	Yes No	Drug Addiction	O Yes	O No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	O Yes	O No	Herpes	O Yes O No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema		○ No	High Blood Pressure	O Yes O No	Rheumatism	Yes No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures		○ No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	_	○ No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst		○ No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	0	○ No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Blood Disease	O Yes O No	Frequent Cough		○ No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea		○ No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches		○ No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Genital Herpes		○ No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Glaucoma		○ No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy Chest Pains	O Yes O No	Hay Fever		○ No	Mitral Valve Prolapse	O Yes O No	Tonsillitis Tuberculosis	O Yes O No
	O Yes O No	Heart Attack/Failure		○ No	Osteoporosis	O Yes O No	Tumors or Growths	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur Heart Pacemaker		○ No	Pain in Jaw Joints	O Yes O No		O Yes O No
Congenital Heart Disorder Convulsions	O Yes O No	Heart Trouble/Disease		○ No	Parathyroid Disease Psychiatric Care	O Yes O No	Ulcers Venereal Disease	O Yes O No
Convuisions	Yes No	Heart Irouble/Disease	O Yes	○ No	Psychiatric Care	O Yes O No	Yellow Jaundice	Yes No
							renowsaunare	0 165 0 140
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:								