Eaglesoft Medical History March 2018

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.

CURRENT PATIENT: Have you had any changes in your health since your last visit? ◯ Yes ◯ No If yes

Are you under a physician's care now? If yes, physicians name and telphone number ◯ 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

Are you on a special diet? ◯ Yes ◯ No

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

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

Other? ☐ If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	◯ Yes ◯ No	Hepatitis or Jaundice	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Chemical Dependency	◯ Yes ◯ No
Blood Pressure Problems	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	General Allergies	◯ Yes ◯ No	Heart Problems	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Jaw or Ear Pain (TMJ)	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Circulatory Problems	◯ Yes ◯ No
Nervous Problems	◯ Yes ◯ No	Back Problems	◯ Yes ◯ No	Respiratory Disease	◯ Yes ◯ No	Swollen Neck Glands	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Epilepsy or seizures	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Radiation Treatments	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No

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

DENTAL PROFILE

1. Do your gums bleed or do you have bad breath? ◯ Yes ◯ No
2. Do you snore? ◯ Yes ◯ No
3. Are you happy with the appearance of your smile; i.e. white fillings, tooth whitening etc? ◯ Yes ◯ No
4. How did you hear about us? Comment
5. What are your expectations of us? Comment
6. Do you have any concerns or fears? ◯ Yes ◯ No If yes

SIGNATURE

Signature of Patient, Parent or Guardian:

X______________________________ Date:__________