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

Patient Name: Birth Date: Date Created:

This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you had an orthopedic total joint (hip,knee,elbow,finger) replacement?	○ Yes ○ No	If yes
Are you taking any medications?	○ Yes ○ No	If yes
Have you taken alendronate or risedronate (Fosamax/Actonel) for osteoporosis?	○ Yes ○ No	If yes
Have you had intravenous bisphosphonates (Aredia/Zometa)	○ Yes ○ No	If yes
Have you had previous infective endocarditis, damaged heart valve or artificial heart valve?	○ Yes ○ No	If yes
Do you have congestive heart failure, cardiovascular disease or congenital heart disease?	○ Yes ○ No	If yes
Do you have neurological, gastrointestinal or autoimmune disease?	○ Yes ○ No	If yes
Are you pregnant or nursing?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	If yes
Have you had any periodontal (gum) treatments?	○ Yes ○ No	If yes
Do you drink bottled, filtered or tap water?	○ Yes ○ No	If yes
Do you have pain, clicking or popping in jaw joints?	○ Yes ○ No	If yes

Have you been diagnosed or have signs of.....

☐ ADD/ADHD	☐ Aspergers	☐ Dementia	☐ Sensory disorder
☐ Alzheimer's	☐ Autism	☐ Excessive worry	☐ Other
☐ Anxiety	☐ Depression	☐ OCD	

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	○ Yes ○ No	If yes
Do you use controlled substances?	☐	If yes

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

Acid reflux/GERD ○ Yes ○ No	Drug addiction ○ Yes ○ No	High blood pressure ○ Yes ○ No	Rapid weight loss ○ Yes ○ No
AIDS/HIV infection ○ Yes ○ No	Eating disorder ○ Yes ○ No	High cholesterol ○ Yes ○ No	Rheumatic fever ○ Yes ○ No
Anemia ○ Yes ○ No	Emphysema ○ Yes ○ No	Irregular heartbeat ○ Yes ○ No	Seasonal allergy ○ Yes ○ No
Angina ○ Yes ○ No	Epilepsy ○ Yes ○ No	Kidney disease ○ Yes ○ No	STD ○ Yes ○ No
Arthritis ○ Yes ○ No	Excessive thirst ○ Yes ○ No	Liver disease ○ Yes ○ No	Sinus trouble ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting/seizures ○ Yes ○ No	Low blood pressure ○ Yes ○ No	Sleep disorder ○ Yes ○ No
Bleeding disorder ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung disease ○ Yes ○ No	Stroke ○ Yes ○ No
Blood sugar ○ Yes ○ No	Headaches ○ Yes ○ No	Mitral valve prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Cancer ○ Yes ○ No	Heart attack ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Heart murmur ○ Yes ○ No	Pacemaker ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Chronic pain ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation ○ Yes ○ No	Ulcers ○ Yes ○ No
Diabetes I or II ○ Yes ○ No	Hepatitis A,B or C ○ Yes ○ No		

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:_____