Time 9:12 AM | Cedar Place Dental | Date 10/24/2018

# Eaglesoft Medical History

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, c

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|---|---|---|
| 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 |
| 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 |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | 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 |

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

Other? ☐ If yes

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

| | | | |
|---|---|---|---|
| AIDS/HIV Positive Yes No | Cortisone Medicine Yes No | Hemophilia Yes No | Radiation Treatments Yes No |
| Alzheimer's Disease Yes No | Diabetes Yes No | Hepatitis A Yes No | Recent Weight Loss Yes No |
| Anaphylaxis Yes No | Drug Addiction Yes No | Hepatitis B or C Yes No | Renal Dialysis Yes No |
| Anemia Yes No | Easily Winded Yes No | Herpes Yes No | Rheumatic Fever Yes No |
| Angina Yes No | Emphysema Yes No | High Blood Pressure Yes No | Rheumatism Yes No |
| Arthritis/Gout Yes No | Epilepsy or Seizures Yes No | High Cholesterol Yes No | Scarlet Fever Yes No |
| Artificial Heart Valve Yes No | Excessive Bleeding Yes No | Hives or Rash Yes No | Shingles Yes No |
| Artificial Joint Yes No | Excessive Thirst Yes No | Hypoglycemia Yes No | Sickle Cell Disease Yes No |
| Asthma Yes No | Fainting Spells/Dizziness Yes No | Irregular Heartbeat Yes No | Sinus Trouble Yes No |
| Blood Disease Yes No | Frequent Cough Yes No | Kidney Problems Yes No | Spina Bifida Yes No |
| Blood Transfusion Yes No | Frequent Diarrhea Yes No | Leukemia Yes No | Stomach/Intestinal Disease Yes No |
| Breathing Problems Yes No | Frequent Headaches Yes No | Liver Disease Yes No | Stroke Yes No |
| Bruise Easily Yes No | Genital Herpes Yes No | Low Blood Pressure Yes No | Swelling of Limbs Yes No |
| Cancer Yes No | Glaucoma Yes No | Lung Disease Yes No | Thyroid Disease Yes No |
| Chemotherapy Yes No | Hay Fever Yes No | Mitral Valve Prolapse Yes No | Tonsillitis Yes No |
| Chest Pains 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 | Tumors or Growths Yes No |
| Congenital Heart Disorder Yes No | Heart Pacemaker Yes No | Parathyroid Disease Yes No | Ulcers Yes No |
| Convulsions Yes No | Heart Trouble/Disease Yes No | Psychiatric Care Yes No | Venereal Disease Yes No |
| | | | Yellow Jaundice 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:_____