## Eaglesoft Medical History Birth Date:

Patient Name:

X

Date Created:

Date:\_\_\_\_\_

to a second												
Ithough dental personnel pri	marily tre	eat the ar	ea in and around	your mou	th, your mo	uth is a pa	rt of your entire body. He	alth problems	that yo	u may have, or medication that	you may be	takin
Are you under a physician's care now?					○No	If yes						
Have you ever been hospitali	r operation?	○Yes	○No	If yes								
Have you ever had a serious	y?	○ Yes ○ Yes ○ Yes ○ Yes	○No ○No	If yes If yes If yes If yes								
Are you taking any medication												
Do you take, or have you tak	Redux?											
Have you ever taken Fosama	or any other											
medications containing bispho Are you on a special diet?		○Yes	○ No									
Do you use tobacco?		○ Yes	_									
Do you use controlled substances?					○ No	If yes						
omen: Are you												
Pregnant/Trying to get pregnant?					ng?			Tal	king oral	contraceptives?		
e you allergic to any of the fo	ollowing?											
Aspirin ☐ Metal			Penicillin Latex				Codeine Sulfa Drugs			Acrylic  Local Anesthetics		
			Псисх									
Other?						If yes						
you have, or have you had,	, any of t	the follow	ing?									
AIDS/HIV Positive	○ Yes	○ No	Cortisone Med	icine	○ 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 Sei	zures	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Scarlet Fever	○Yes ○	) No
Artificial Heart Valve	○ Yes	○ No	Excessive Blee	ding	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Shingles	○Yes ○	) No
Artificial Joint	○ Yes	○ No	Excessive Thirs	st	○ 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 Coug	jh	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Spina Bifida	○Yes ○	) No
Blood Transfusion	○ Yes	○ No	Frequent Diarr	hea	○ Yes	○ No	Leukemia	○ Yes	○ No	Stomach/Intestinal Disease	O Yes	) No
Breathing Problems	○ Yes	○ No	Frequent Head	laches	○ Yes	○ No	Liver Disease	○ Yes	○ No	Stroke	○Yes ○	) No
Bruise Easily	○ Yes		Genital Herpes		○ Yes		Low Blood Pressure	○Yes		Swelling of Limbs	○Yes ○	
Cancer	○ Yes		Glaucoma		○ Yes		Lung Disease	○ Yes		Thyroid Disease	O Yes	
Chemotherapy	○ Yes		Hay Fever		○ Yes	_	Mitral Valve Prolapse	○ Yes		Tonsillitis	O Yes	
Chest Pains	○ Yes	_	Heart Attack/F	ailure	○ Yes		Osteoporosis	○ Yes		Tuberculosis	O Yes	
Cold Sores/Fever Blisters	○ Yes		Heart Murmur		○ Yes	_	Pain in Jaw Joints	○ Yes	_	Tumors or Growths	O Yes C	
Congenital Heart Disorder	○ Yes	_	Heart Pacemak	ær	○ Yes		Parathyroid Disease	○ Yes	_	Ulcers	O Yes C	
Convulsions	O Yes	_	Heart Trouble/		○ Yes		Psychiatric Care	○ Yes	_	Venereal Disease	O Yes C	
	0.03	0.10	,		0.03	0110		0.163	O 140	Yellow Jaundice	O Yes C	
Have you ever had any serio	us illness	not listed	l above?	○ Yes	○ No	If yes	I			l		
omments:												
he heet of my knowledge the	ie griochi-	one on the	o form have be	300.004-	ly appropriate	Lunder	stand that providing income	act information	n can h-	dangerous to my for anti	hasith Tt:	c r
the best of my knowledge, th					ly answered	. I unders	stand that providing incorre	ect informatio	n can be	dangerous to my (or patient's	) health. It i	s my
					ly answered	. I unders	stand that providing incorre	ect informatio	n can be	dangerous to my (or patient's	) health. It i	s my