Eaglesoft Medical History 2

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,

Are you having pain or discomfort at this time?	◯ Yes ◯ No	If yes
Do you fee nervous about having dental treatment?	◯ Yes ◯ No	If yes
Have you had a bad experience at the dental office?	◯ Yes ◯ No	If yes
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
Are you taking any medications, pills or drugs?	◯ Yes ◯ No	If yes

Medication List

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
☐ Ibuprofen

Other? ☐ If yes

List your reaction (i.e. itching, rash,swelling) ◯ Yes ◯ No

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

Heart attack/disease	◯ Yes ◯ No	Premed	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Artificial Hip/Knee	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Artificial Joint/Other	◯ Yes ◯ No	Dry Mouth/ Xerostomia	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	GERD (acid reflux)	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No
Heart Murmur/ Arrhythmia	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Epilesy / Seizures	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Recent Weight Loss/ Gain	◯ Yes ◯ No	Cold Sores / Fever Blister	◯ Yes ◯ No
Artificail Heart Valve	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Canker sores	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Radiation	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Migraines	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Alzheimer's\Dementia	◯ Yes ◯ No
Thyroid Disease	◯ Yes ◯ No	Arthitis	◯ Yes ◯ No	Depression	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Taking Blood Thinners	◯ Yes ◯ No	Problems Sitting Back	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Psychiatric Treatment	◯ Yes ◯ No
AIDS/ HIV +	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Seasonal Allergies	◯ Yes ◯ No
Kidney Trouble	◯ Yes ◯ No	Alcoholism	◯ Yes ◯ No	Tobacco Use	◯ Yes ◯ No
Head/Neck Trauma	◯ Yes ◯ No	Osteoporosis Medication	◯ Yes ◯ No	Marijuana Use	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ 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:_____