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

Patient Name: Birth Date: Date Created:

Are you under Medical Treatment now? If yes, please explain:	O Yes	O No	If yes	
Have you ever been hospitalized? If yes, please explain:	O Yes	O No	If yes	
Are you taking any medications, pills, or drugs? Please list d ru g s:	O Yes	O No	If yes	
Do you use alcohol?	O Yes	O No	If yes	
Are you wearing Contact Lenses?	O Yes	O No		
Do you (Jse Tobacco?	O Yes	O No	If yes	
Do you use controlled substances? If Yes Please Explain:	O Yes	O No		

Women: Are you —

|P Pregnant orTrying to get pregnant? [__Taking oral contraceptives? [? Nursing?

Are you allergic to any of the following?

[— Aspirin	I Penicillin	| Codeine	Local Anesthetics
| Acrylic	| ~ Metal	[p~ Latex	[p^ Sulfa Drugs

Other? If yes please explain: o If yes 1

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

Aid/HIV Positive	O Yes	O No	Alzheimer's Disease	O Yes	O No
Anaphylaxis	O Yes	O No	Anemia	O Yes	O No
Angina	O Yes	O No	Arth riti s/Gout	O Yes	O No
Artificial HeartValve	O Yes	O No	Artif i ci a 1 J o int	O Yes	O No
Asthma	O Yes	O No	Blood Disease	O Yes	O No
Blood Transfusion	O Yes	O No	Breathing Problems	O Yes	O No
Bruise Easily	O Yes	O No	Cancer	O Yes	O No
Chemotherapy	O Yes	O No	Chest Pains	O Yes	O No
Cold Sores/ Fever Blisters	O Yes	O No	Congenital Heart Disorder	O Yes	O No
Convulsions	O Yes	O No	Cortisone Medicine	O Yes	O No
Diab etes	O Yes	O No	Drug Addiction	O Yes	O No
Easily Winded	O Yes	O No	Emphysema	O Yes	O No
Epilepsy or Seizures	O Yes	O No	Excessive Bleeding	O Yes	O No
Excessive Thirst	O Yes	O No	Fainting Spells/Dizziness	O Yes	O No
Frequent Cough	O Yes	O No	Frequent Diarrhea	O Yes	O No
Genital Herpes	O Yes	O No	Glaucoma	O Yes	O No
Hay Fever	O Yes	O No	Heart Attack/ Failure	O Yes	O No
Heart Murmur	O Yes	O No	Heart Pacemaker	O Yes	O No
Heart Troub 1 e/D i s ease	O Yes	O No	Hepatitis A	O Yes	O No
Hemophilia	O Yes	O No	Hepatitis B orC	O Yes	O No
Herpes	O Yes	O No	High Blood Pressure	O Yes	O No
High Cholesterol	O Yes	O No	Hives or Rash	O Yes	O No
Hypoglycemia	O Yes	O No	Irregular Heartbeat	O Yes	O No
Kidney Problems	O Yes	O No	Leukemia	O Yes	O No
Liver Disease	O Yes	O No	Low Blood Pressure	O Yes	O No
Lung Disease	O Yes	O No	Mitral Valve Prolapse	O Yes	O No
O steo porosis	O Yes	O No	Pain in Jaw Joints	O Yes	O No
Parathyroid Disease	O Yes	O No	Psychiatric Care	O Yes	O No
Radiation Therapy	O Yes	O No	Recent Weight Loss	O Yes	O No
Renal Dialysis	O Yes	O No	Rheumatic Fever	O Yes	O No
Rh eu m a ti s m	O Yes	O No	Scarlet Fever	O Yes	O No
Shingles	O Yes	O No	Sickle Cell Disease	O Yes	O No
Sinus Trouble	O Yes	O No	Spina Bifida	O Yes	O No
Stomach/Intestinal Disease	O Yes	O No	Stro ke	O Yes	O No
Swelling of Limbs	O Yes	O No	Thyroid Disease	O Yes	O No
Tonsillitis	O Yes	O No	Tuberculosis	O Yes	O No
Tumors/G rowth	O Yes	O No	Ulcers	O Yes	O No
Venereal Disease	O Yes	O No			

Dental History

Doyourgums bleed while brushing orflo	O Yes	O No	Are your teeth sensitive to hot or cold	O Yes	O No
Are your teeth sensitiveto sweet or sou	O Yes	O No	Do you feel pain to any of yourteeth?	O Yes	O No
Do you have sores or lumps in or nearyo	O Yes	O No	H i sto ry of Peri o d o nta 1 Th erapy?	O Yes	O No
Do you Snore orhaveyou been told you s	O Yes	O No	Haveyou ever Reci eved oral hygiene inst	O Yes	O No
Have you had any Head, neck or jaw injur	O Yes	O No	Do you bite your liips or cheeks frequen	O Yes	O No
Haveyou ever had any difficult extracti	O Yes	O No	Haveyou had orthodontictreatment?	O Yes	O No
Have you ever experienced prolonged blee	O Yes	O No	Do you wearpartials or dentures?	O Yes	O No
Do you have frequent headaches?	O Yes	O No	Do you clench or grind yourteeth?	O Yes	O No
Haveyou ever experienced any of thefol	O Yes	O No	Clicking, popping?	O Yes	O No
Pain floint,ear,side of face)?	O Yes	O No	Difficulty in opening orclosing?	O Yes	O No
Difficulty in chewing?	O Yes	O No	Is there anything you would like to chan	O Yes	O No

If yes What? Yes O No

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:_____