Kempeinen Dentistry P.C.

New Eaglesoft Medical History

Patient Name:

X

Birth Date:

Date Created:

Date:__

Arte you under a physician's care now? Yes No If yes	Are you under a physician's												
Hair y ou ever taken Fosamax, Boriva, Adooel or any other		care nov	w?		○ Yes	○No	If yes						
medications containing bisphosphonoute? Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to take an antibiotic premedication prior to Over led to Ove	Have you ever been hospital	lized or l	had a ma	ajor operation?	○ Yes	○ No	If yes						
Are you taking a blood thinmer? O'Yes ONO If yes Are you taking a blood thinmer? O'Yes ONO If yes Are you taking any medication(s) including non-prescription O'Yes ONO Are you taking any medication(s) including non-prescription O'Yes ONO If yes O'Medications:				nel or any other	○ Yes	○ No	If yes						
Do you use tobacco?		oiotic pre	emedicat	tion prior to	○ Yes	○ No	If yes						
Arthritis Yes No Diabytes Yes No If yes Yes No If yes Yes No If yes No If yes Yes No If yes	Are you taking a blood thinn	ner?			○ Yes	○ No	If yes						
omen: Are you omen: Are yo	Oo you use tobacco?				○ Yes	○ No	If yes						
oment: Are you Pregnant? If yes, what's your due date? Ves No					○ Yes	○No							
Pregnant? If yes, what's your due date? Yes No Yes No Taking oral contraceptives? Yes No Taking oral contraceptives? Yes No Yes No Yes No Taking oral contraceptives? Yes No Yes No Te you allergic to any of the following? Acrylic	t of Medications:												
Pregnant? If yes, what's your due date? Yes No Yes No Taking oral contraceptives? Yes No Taking oral contraceptives? Yes No Yes No Yes No Taking oral contraceptives? Yes No Yes No Te you allergic to any of the following? Acrylic													
Nursing? Yes No Local Anesthetics Penicillin Sulfa Drugs Other? Yes No If yes Metal Sulfa Drugs Other? Yes No Heart Trouble/Disease Yes No Mitral Valve Prolapse Yes Oral Arthritis Yes No Dialysis Yes No Hepatitis C Yes No Osteoporosis Yes Oral Arthritis Yes No Drug Addiction Yes No High Blood Pressure Yes No Pain in Jaw Joints Yes Oral Arthritial Joint Yes No Epilepsy or Seizures Yes No Jundice Yes No Radiation Treatment Yes Oral Bleeding Problem Yes No Fainting Spells/Dizziness Yes No Leukemia Yes No Stomach/Intestinal Disease Yes Oral Cancer Yes No Heart Hailure Yes No Leukemia Yes No Stroke Yes Oral Congenital Heart Disorder Yes No Heart Pacemaker Yes No Lung Disease Yes No Tuberculosis Yes Oral Congenital Heart Disorder Yes No Heart Pacemaker Yes No Lung Disease Yes No Tuberculosis Yes Oral Congenital Heart Disorder Yes No No No No No No No N	omen: Are you												
Taking oral contraceptives? Yes No		r due da	ite?		○ Yes	○ No	If yes						
e you allergic to any of the following? Acrylic	Nursing?				○ Yes	○ No							
Acrylic	Taking oral contraceptives?				○ Yes	○No							
Deter?		ollowing?									- Desirilia		
Other? Oyou have, or have you had, any of the following? AIDS/HIV Positive				_									
Arthritis Yes No Dialysis Yes No Heart Trouble/Disease Yes No Osteoporosis Yes Official HeartValve Yes No Dialysis Yes No Heart Trouble/Disease Yes No Osteoporosis Yes Official HeartValve Yes No Dialysis Yes No Heart Trouble/Disease Yes No Osteoporosis Yes Official HeartValve Yes No Drug Addiction Yes No High Blood Pressure Yes No Pain in Jaw Joints Yes Official Joint Yes No Emphysema Yes No Irregular Heartbeat Yes No Psychiatric Care Yes Official Joint Yes No Epilepsy or Seizures Yes No Jaundice Yes No Radiation Treatment Yes Official Problem Yes No Fainting Spells/Dizziness Yes No Kidney Problems Yes No Sleep Apnea Yes Official Problem Yes No Heart Attack Yes No Leukemia Yes No Stomach/Intestinal Disease Yes Official Problem Yes No Heart Murmur Yes No Liver Disease Yes No Thyroid Disease Yes Official Heart Disorder Yes No Heart Pacemaker Yes No Lung Disease Yes No Tuberculosis Yes Official Problem Yes No Tuberculosis Yes Official Problem Yes No Tuberculosis Yes Official Problem Yes Official Problem Yes No Tuberculosis Yes Official Problem Yes Official Problem Yes No Tuberculosis Yes Official Problem Yes	Aspinii			Latex				Metal			Sulla Drugs		
AIDS/HIV Positive	Other?				○ Yes	○ No	If yes						
Arthritis	you have, or have you had,	any of t	he follow	ving?									
Artificial HeartValve	AIDS/HIV Positive	○ Yes	○ No	Diabetes		○ Yes	○ No	Heart Trouble/Disease	○ Yes	○ No	Mitral Valve Prolapse	○ Yes	O
Artificial Joint	Arthritis	○ Yes	○ No	Dialysis		○ Yes	○ No	Hepatitis C	○ Yes	○ No	Osteoporosis	○ Yes	0
Asthma	Artificial Heart Valve	○ Yes	○ No	Drug Addiction		○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Pain in Jaw Joints	○ Yes	0
Bleeding Problem	Artificial Joint	○ Yes	○ No	Emphysema		○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Psychiatric Care	○ Yes	0
Breathing Problem	Asthma	○ Yes	○ No	Epilepsy or Sei	zures	○ Yes	○ No	Jaundice	○ Yes	○ No	Radiation Treatment	○ Yes	O
Cancer	Bleeding Problem	○ Yes	○ No	Fainting Spells	/Dizziness	Yes	○ No	Kidney Problems	○ Yes	○ No	Sleep Apnea	○ Yes	0
Chemotherapy	Breathing Problem	○ Yes	○ No	Heart Attack		○Yes	○ No	Leukemia	○ Yes	○ No	Stomach/Intestinal Disease	○ Yes	0
Congenital Heart Disorder	Cancer	○ Yes	○ No	Heart Failure		○Yes	○ No	Liver Disease	○ Yes	○ No	Stroke	○ Yes	0
	Chemotherapy	○ Yes	○ No	Heart Murmur		○Yes	○ No	Low Blood Pressure	○ Yes	○ No	Thyroid Disease	○ Yes	ON
you have any other disease, condition, or problem not listed above?	Congenital Heart Disorder	○ Yes	○ No	Heart Pacemak	er	○ Yes	○ No	Lung Disease	○Yes	○ No	Tuberculosis	○ Yes	0
) you have any other disease	e, condition	on, or pr	oblem not listed ab	ove?			1					
	you have any other disease	e, <mark>cond</mark> itio	on, or pro	oblem not listed ab	ove?								