Eaglesoft Medical History (office use only)

Patient Name: Birth Date: Date Created:

Patient name:		Comment	
Date of birth:		Comment	
Physician's name:		Comment	
Date of most recent visit to physician:		Comment	
Reason:		Comment	

Have you been hospitalized within the last year? If yes, explain:	◯ Yes ◯ No	If yes
Have you had a serious illness or operation within the last year? If yes, explain:	◯ Yes ◯ No	If yes
Have you ever had any serious medical trouble associated with a dental experience? If yes, explain:	◯ Yes ◯ No	If yes
Have you been advised to take antibiotics before a dental appointment? If yes, explain:	◯ Yes ◯ No	If yes
Do you smoke? If yes, how many cigartettes a day?	◯ Yes ◯ No	If yes
Do you chew tobacco? If yes, how often?	◯ Yes ◯ No	If yes
If you were a tobacco user when did you quit?		
Current blood pressure, if known		

Do you now or have you had any of the following cardiovascular diseases? If yes, check all that apply

Heart disease	◯ Yes ◯ No	Coronary bypass	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Heart attack	◯ Yes ◯ No
Mitral valve prolapse	◯ Yes ◯ No	Heardening of the arteries	◯ Yes ◯ No
High blood pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Heart murmur	◯ Yes ◯ No	Congestive heart failure	◯ Yes ◯ No
Rhuematic fever/heart disease	◯ Yes ◯ No	Congenital heart defect	◯ Yes ◯ No
Artficial heart valves	◯ Yes ◯ No	Pacemaker	◯ Yes ◯ No
High cholesterol	◯ Yes ◯ No	Swelling of ankles	◯ Yes ◯ No
Shortness of breath after mild exercise	◯ Yes ◯ No	Shortness of breath when you lie down	◯ Yes ◯ No

Do you have diabetes?	◯ Yes ◯ No		
If yes, do you require insulin?	◯ Yes ◯ No		
Type _____ Dose _____		Comment	

Artificial Joint(s)	◯ Yes ◯ No	OFFICE USE ONLY: Pre-med Needed:	◯ Yes ◯ No
If yes, which joint(s)		Comment	

Hepatitis. If yes, check type: Type A_____ Type B_____ Type C_____ Don't Know_____ Non-specific Type_____			
Required a blood transfusion due to hepatitis? If yes, when	◯ Yes ◯ No	If yes	

WOMEN ONLY:

☐ Are you pregnant/trying to get pregnant? ☐ Are you on hormone replacement therapy? ☐ Are you taking birth control

If you are pregnant, how many weeks?

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

AIDS/HIV Positive	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ 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
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	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Tumors or Growths	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No	Vertigo	◯ Yes ◯ No
GERD	◯ Yes ◯ No	Acid Reflux	◯ Yes ◯ No	Car Sickness	◯ Yes ◯ No	Sleep Apnea	◯ Yes ◯ No
History of Biopsy	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Rhuematic Fever	◯ Yes ◯ No		

Do you have any disease, condition, or medical problem not listed you feel we should know about? If yes, please list ◯ Yes ◯ No If yes

Are you allergic to any of the following?

Aspirin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No	Acrylic	◯ Yes ◯ No
Metal	◯ Yes ◯ No	Latex	◯ Yes ◯ No
Sulfa drugs	◯ Yes ◯ No	Local anesthetics	◯ Yes ◯ No
Pine nuts	◯ Yes ◯ No	Barbituates/sedatives	◯ Yes ◯ No
Tranquilizers	◯ Yes ◯ No		

Have you ever had an adverse reaction (nausea, dizziness) to any drug or medication? ◯ Yes ◯ No If yes

Please list any CURRENT medications you are taking and health reason for taking:

Do you use controlled substances? ◯ Yes ◯ No If yes

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:_____

Additional comments: