

Eaglesoft Medical History

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

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?

Women: Are you...

- Pregnant/Trying to get pregnant?
Nursing?
Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin, Metal, Penicillin, Latex, Codeine, Sulfa Drugs, Acrylic, Local Anesthetics

Other?

Do you use controlled substances?

- Yes/No radio buttons and text boxes for 'If yes' responses.

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

- Grid of medical conditions including AIDS/HIV, Diabetes, Hemophilia, Radiation Treatments, etc., with Yes/No radio buttons.

Have you ever had any serious illness not listed? Yes/No radio buttons and 'If yes' text box.

Comments:

Large empty rectangular box for patient 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: \_\_\_\_\_