## Eaglesoft Medical History Birth Date:

Patient Name:

Date Created:

Date:

		10 222		10 0	fi bes	Manager and part of 1969 (	aithe nook. use	ith problems that you may	have, or med
Have you ever been hosp	Are you under a physician's care now?				If yes	,			
Have you ever been hospitalized or had a major operation?			© Yes © No		If yes				
Have you ever had a seri	ous head or no	eck injury?	O Yes	P) No	If yes				
Are you taking any medic	© Yes © No If y  © Yes © No If y		If yes						
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?			If yes		***************************************				
			If yes						
Do you use tobacco?			© Yes (	2000000					
•			C res (	, NO		75.16		Self. 522	
		28			*				
Vomen: Are you	. B20	a area mana					2	8 18/18	
Pregnant/Trying to get	t pregnant?		O Nursin	g?			Taking o	ral contraceptives?	
re you allergic to any of the	e following?								
☐ Aspirin	me-nove herocolori more <b>→</b> one	Penicillin			5 90	Codeine Codeine		☐ Acrylic	4 1
☐ Metal		☐ Latex				Sulfa Drugs		Local Anesthetics	
Other?					If yes				
Do you use controlled sub	stances?		⊕ Yes €	) No	If yes				
7					т Асэ				
o you have, or have you ha	141	1	8	1.75		* 100 100 1			6 10
	O Yes O No	Cortisone Med	licine	O Yes	200	Hemophilia	⊘ Yes ⊘ No	Radiation Treatments	O Yes O N
200 SEC 19 10 10 10 10 10 10 10 10 10 10 10 10 10	Yes () No	Diabetes		Yes		Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O N
	Yes () No	Drug Addiction		Yes	⊘ No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O N
	Yes O No	Easily Winded		Yes	O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O N
And the second second	O Yes O No	Emphysema			<b>⊘</b> No	High Blood Pressure	Yes No	Rheumatism	O Yes ON
	Yes No	Epilepsy or Se	lzures	O Yes		High Cholesterol	Yes No	Scarlet Fever	O Yes ON
	Yes No	Excessive Blee	eding	O Yes	⊘ No	Hives or Rash	O Yes O No	Shingles	O Yes O N
	Yes O No	Excessive Thir	st	O Yes	⊗ No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes ON
Asthma (	Tes O No	Fainting Spells/	Dizziness		O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes ON
Blood Disease (	Yes O No	Frequent Cour	gh		⊘ No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O N
Blood Transfusion (	Yes O No	Frequent Dian	rhea	© Yes	O No	Leukemia		Stomach/Intestinal Disease	© Yes ⊙ N
Breathing Problems	Yes ( No	Frequent Head	daches	O Yes		Liver Disease	O Yes O No	Stroke	O Yes O N
Bruise Easily (	Yes O No	Genital Herpes	5	O Yes	O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O N
Cancer (	Yes O No	Glaucoma		Yes		Lung Disease	O Yes O No		Ø Yes Ø N
Chemotherapy (	Yes O No	Hay Fever		O Yes		Mitral Valve Prolapse	O Yes O No	Thyroid Disease Tonsillitis	
	Yes O No	Heart Attack/F	allura	© Yes		Osteoporosis	O Yes O No		O Yes O N
Cold Sores/Fever Blisters (		Heart Murmur		Ø Yes		Pain in Jaw Joints		Tuberculosis	O Yes ON
Congenital Heart Disorder		Heart Pacema		⊘ Yes	75.0	e de la companya de l	O Yes O No	Tumors or Growths	Ø Yes Ø N
	Yes ( No	Heart Trouble	and the			Parathyroid Disease Psychiatric Care		Ulcers	O Yes ON
		Lucar Finance	niscase	0 163	C IN	PSYCHIANTIC LARP		Venereal Disease	