

Eaglesoft Medical History Updated 2021

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 that you may be taking, c

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?
Have you had a COVID-19 vaccine?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you...

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

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

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

AIDS/HIV Positive Cortisone Medicine Radiation Treatments Alzheimer's Disease
Diabetes Hepatitis A, B or C Anaphylaxis Drug Addiction
Anemia Easily Winded Herpes Rheumatic Fever
Angina High/Low Blood Pressure Rheumatism Arthritis/Gout
Epilepsy or Seizures High Cholesterol Scarlet Fever Artificial Heart Valve
Excessive Bleeding Hives or Rash Shingles Artificial Joint
Hypoglycemia Asthma Fainting Spells/Dizziness Irregular Heartbeat
Sinus Trouble Blood Disease Frequent Cough Kidney Problems
Spina Bifida Leukemia Stomach/Intestinal Disease Breathing Problems
Frequent Headaches Liver Disease Stroke Bruise Easily
Swelling of Limbs Cancer Glaucoma Lung Disease
Thyroid Disease Chemotherapy Hay Fever Mitral Valve Prolapse
Chest Pains Osteoporosis Tuberculosis Heart Murmur
Pain in Jaw Joints Tumors or Growths Heart Pacemaker Parathyroid Disease
Ulcers Heart Trouble/Disease Psychiatric Care Yellow Jaundice

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: