

Eaglesoft Medical History version 2021(Use)

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

Do you have a primary physician? Please list their name and phone number.  Yes  No If yes

Have you ever been hospitalized or had a major operation?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Do you have any artificial joints? Please list joints and dates of surgery.  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Have you ever taken osteoporosis medications like bisphosphonates, Fosamax, Boniva, or Actonel?  Yes  No If yes

Are you on a blood thinner (anticoagulant)?  Yes  No If yes

Do you use tobacco products or vapes?  Yes  No If yes

Have you had a COVID-19 Vaccine? When?  Yes  No If yes

Have you ever tested positive for COVID-19? When? Any symptoms still present?  Yes  No If yes

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

Do you use controlled substances?  Yes  No If yes

Other?  If yes

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

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Angina/Chest Pain <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Autoimmune Disorder <input type="radio"/> Yes <input type="radio"/> No
Bleeding Disorder/Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No
Diabetes <input type="radio"/> Yes <input type="radio"/> No	Difficulty Breathing/Oxygen Needed <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Genital or Oral Herpes <input type="radio"/> Yes <input type="radio"/> No	Heart Attack or Heart Failure <input type="radio"/> Yes <input type="radio"/> No
Heart Disease <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No
Kidney Dialysis <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
Radiation Treatment <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Shingles <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Stomach Reflux/GERD <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disorder <input type="radio"/> Yes <input type="radio"/> No	TMJ pain or disorder <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Ulcers in GI tract <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease/STD <input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above?  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: \_\_\_\_\_