Happy Smiles Dental

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Have you been under a physician's care in the last 2 years?	○ Yes ○ No	If yes
Have you had any serious illness, operation or hospitalized?	○ Yes ○ No	If yes
Have you ever been sick from dental treatments?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use tobacco or drink alcoholic beverages?	○ Yes ○ No	If yes
Have you had any surgery or plan to have surgery?	○ Yes ○ No	If yes
Do you get short of breath after climbing 1 flight of stairs?	○ Yes ○ No	If yes
Are you a "bleeder" or have you had excessive bleeding following dental treatment?	○ Yes ○ No	If yes
Have you been subjected to abuse or neglect?	○ Yes ○ No	If yes
(Female only) Are you pregnant, nursing or planning on pregnancy?	○ Yes ○ No	If yes

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

Cortisone Medicine	○ Yes ○ No	Diabetes	○ Yes ○ No	Herpes	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Asthma	○ Yes ○ No	Blood Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Cancer	○ Yes ○ No	Lung Disease	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Tuberculosis	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No
Venereal Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No	Epilepsy	○ Yes ○ No	Glaucoma	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Hives/Rash	○ Yes ○ No
Kidney Disease	○ Yes ○ No	Sinus Disease	○ Yes ○ No	Hemophilia	○ Yes ○ No	Hepatitis	○ Yes ○ No

Have you ever had any serious illness not listed above?	○ Yes ○ No	If yes
ARE YOU ALLERGIC TO ANY DRUGS OR MEDICINE (NOVACAINE, PENICILLIN, OTHERS?) EXPLAIN IN	○ Yes ○ No	
IF YOU COULD CHANGE ONE THING ABOUT YOUR SMILE, WHAT WOULD IT BE? EXPLAIN IN COMMENTS	○ Yes ○ No	

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:_____