

Eaglesoft Medical History-- Revised 1/03/2023

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

Have you ever had any chemo or radiation treatment?  Yes  No If yes

Are you taking any medications, pills, or drugs?  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

Have you taken any of these medications in the past?

Sutent <input type="radio"/> Yes <input type="radio"/> No	Fosamax <input type="radio"/> Yes <input type="radio"/> No	Zometa <input type="radio"/> Yes <input type="radio"/> No	Nexavar <input type="radio"/> Yes <input type="radio"/> No
Actonel <input type="radio"/> Yes <input type="radio"/> No	Reclast <input type="radio"/> Yes <input type="radio"/> No	Avastin <input type="radio"/> Yes <input type="radio"/> No	Boniva <input type="radio"/> Yes <input type="radio"/> No
Xgeva <input type="radio"/> Yes <input type="radio"/> No	Rapamune <input type="radio"/> Yes <input type="radio"/> No	Aredia <input type="radio"/> Yes <input type="radio"/> No	Prolia <input type="radio"/> Yes <input type="radio"/> No

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

Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <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	Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No
Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
Venereal Disease <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No	Epilepsy <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Hives/Rash <input type="radio"/> Yes <input type="radio"/> No
Kidney Disease <input type="radio"/> Yes <input type="radio"/> No	Sinus Disease <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Hepatitis <input type="radio"/> Yes <input type="radio"/> No
HIV <input type="radio"/> Yes <input type="radio"/> No			

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED?  Yes  No If yes

ARE YOU ALLERGIC TO ANY DRUGS OR MEDICINE?  Yes  No If yes

HAVE YOU EVER TAKEN ANY MEDICATIONS TO TREAT CANCER OR OSTEOPOROSIS? PROVIDE WHEN AND TYPE  Yes  No If yes

ARE YOU AWARE THAT A LACK OF TOOTH PAIN MAY NOT BE AN INDICATOR OF WELLNESS?  Yes  No

IF YOU COULD CHANGE ONE THING ABOUT YOUR SMILE, WHAT WOULD IT BE? PLEASE WRITE IN BELOW

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: \_\_\_\_\_