Eaglesoft Medical History- 2025 (Copy)

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? Name of PCP and specialists.	◯ 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
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
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you vape?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you use marijuana?	◯ Yes ◯ No	
On a scale of 1-5, 5 being most fearful, how fearful are you of the dentist?		

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

☐ Foods/Dyes

Other? ☐ If yes

Have you ever had any serious illness not listed below? ◯ Yes ◯ No If yes

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

Acid Reflux/GERD	◯ Yes ◯ No	ADHD	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Arthritis	◯ Yes ◯ No	Artifical Heart Valve	◯ Yes ◯ No
Artificial Joint Replacement	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Autoimmune Disorders	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Carpal Tunnel	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Chest Pain	◯ Yes ◯ No	Cold sores/Fever blisters	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Cortisone Medicine	◯ Yes ◯ No	Dementia	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Eating Disorder	◯ Yes ◯ No	Emotional Disorder	◯ Yes ◯ No	Epilepsy/Seizure Disorder	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Eye Conditions	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Hepatitis A, B, or C	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Neurological Conditions	◯ Yes ◯ No	Radiation	◯ Yes ◯ No
Sinus Troubles	◯ Yes ◯ No	Sjogren's	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No						

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:_____