## Page Family Dentistry **Eaglesoft Medical History**

Patient Name:

Birth Date: Date Created:

Although dental personnel pr	rimarily tr	reat the are	ea in and around	your mou	th, your mo	uth is a pa	rt of your entire body. He	alth problem	s that yo	u may have, or medication that	you may	be taking
Are you under a physician's care now?					○ No	If yes						
Have you ever been hospitalized or had a major operation?					○ No	If yes						
Have you ever had a serious head or neck injury?					○No	If yes						
Are you taking any medications, pills, or drugs?					○No	If yes						
Do you take, or have you taken, Phen-Fen or Redux?					○No	If yes						
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?					○No	If yes						
Are you on a special diet?					○ No							
Do you use tobacco?					○ No							
Do you use controlled substances?					○ No	If yes						
Momoni Aro vou												
Nomen: Are you  Pregnant/Trying to get p	oregnant	:?		Nursi	ng?			Ta	aking ora	l contraceptives?		
				_								
Are you allergic to any of the	following	?	□ Donisillin				□ Codeine			□ A coulic		
			Penicillin  Latex			Codeine Sulfa Drugs			☐ Acrylic ☐ Local Anesthetics			
Other?						If yes						
Do you have, or have you had	d, any of	the followi	ng?									
AIDS/HIV Positive	○ Yes	○ No	Cortisone Med	idne	○ Yes	○ No	Hemophilia	○ Yes	○ No	Radiation Treatments	○ Yes	○No
Alzheimer's Disease	○ Yes	○No	Diabetes		○ Yes	○ No	Hepatitis A	○ Yes	○ No	Recent Weight Loss	○ Yes	○ No
Anaphylaxis	○ Yes	○ No	Drug Addiction		○ Yes	○ No	Hepatitis B or C	○ Yes	○ No	Renal Dialysis	○ Yes	○ No
Anemia	○ Yes	○ No	Easily Winded		○ Yes	○ No	Herpes	○ Yes	○ No	Rheumatic Fever	○ Yes	○ No
Angina	○ Yes	○ No	Emphysema		○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Rheumatism	○ Yes	○ No
Arthritis/Gout	○ Yes	○ No	Epilepsy or Sei	zures	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Scarlet Fever	○ Yes	○ No
Artificial Heart Valve	○ Yes	○ No	Excessive Blee	ding	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Shingles	○ Yes	○ No
Artificial Joint	○ Yes	○No	Excessive Thirs	t	○ Yes		Hypoglycemia	○ Yes	○ No	Sickle Cell Disease	○ Yes	○ No
Asthma		○No	Fainting Spells	/Dizziness	_		Irregular Heartbeat	○ Yes		Sinus Trouble	○ Yes	
Blood Disease	_	○ No	Frequent Coug		_	○ No	Kidney Problems	○ Yes	_	Spina Bifida	○ Yes	
Blood Transfusion		○ No	Frequent Diarr			○ No	Leukemia	○ Yes		Stomach/Intestinal Disease	○ Yes	
Breathing Problems		○ No	Frequent Head	aches		○ No	Liver Disease	○ Yes		Stroke	○ Yes	
Bruise Easily		○ No	Genital Herpes		○ Yes	_	Low Blood Pressure	○ Yes	_	Swelling of Limbs	○ Yes	
Cancer		○No	Glaucoma Hay Fever			○ No	Lung Disease	○ Yes		Thyroid Disease Tonsillitis	○ Yes	
Chest Pains		○No ○No	Heart Attack/F	ailura		○ No ○ No	Mitral Valve Prolapse Osteoporosis	○ Yes ○ Yes		Tuberculosis	○ Yes ○ Yes	
Cold Sores/Fever Blisters		○ No	Heart Murmur	anure		○ No	Pain in Jaw Joints	○ Yes		Tumors or Growths	O Yes	
Congenital Heart Disorder	_	○ No	Heart Pacemak	er		○ No	Parathyroid Disease	○ Yes	_	Ulcers	O Yes	_
Convulsions	_	○ No	Heart Trouble/			○ No	Psychiatric Care	○ Yes		Venereal Disease	○ Yes	_
Yellow Jaundice		○ No			0.4	O		0.44	O		0.44	· · · ·
Have you ever had any serie	ous illne	ss not liste	ed above?	○ Yes	○ No	If yes						
				Tes	ONO	11 YES						
Comments:												
o the best of my knowledge. t	he guest	tions on this	s form have been	accurate	lv answered	l. Lunders	stand that providing incorre	ect informatio	on can he	e dangerous to my (or patient's)	health. 1	It is mv
esponsibility to inform the dent					,				22.7	.g, (or positive)		,
Signature of Patient, Parent o	or Guardia	an:										
X									г	ate:		
^									L	a.c		