Time 11:30 AM | Dental Health Clinic P.A. | Date 10/12/2022

Eaglesoft Medical History**

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

Medical

Are you under a physician's care now for a specific concern? If yes, please list concern and Dr's contact information	◯ Yes ◯ No	If yes
Does your MD require you to take an antibiotic before dental treatment for a specific health condition?	◯ Yes ◯ No	If yes
Are you taking any blood thinner/baby aspirin? Please describe	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications for osteoporosis?	◯ Yes ◯ No	If yes
Are you taking any other medications? PLEASE LIST ALL BELOW (include birth control)	◯ Yes ◯ No	

Medications

Have you had previous trauma to your jaw?	◯ Yes ◯ No	If yes
Do you use tobacco/smokeless tobacco	◯ Yes ◯ No	
Pregnant? If so, what is your due date?	◯ Yes ◯ No	If yes

Drug Allergies

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Sulfa Drugs	☐ Codine
☐ Latex	☐ Metal		

Any other drug related allergies?	◯ Yes ◯ No	If yes

Current Health

Do you have any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Alzheimer's Disease ◯ Yes ◯ No	Anaphylaxis ◯ Yes ◯ No	Angina ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Asthma ◯ Yes ◯ No	Blood Disease ◯ Yes ◯ No	Breathing Problems ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No
High Blood Pressure ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No
Pain in Jaw Joint ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Radiation Treatment ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Stroke ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Stomach/Intestinal Disease ◯ Yes ◯ No	Eating disorder ◯ Yes ◯ No		

Any other serious medical condition/concerns not listed above that you feel is pertinent to your care? Please explain	◯ 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:_____