Eaglesoft Medical History Birth Date:

Patient Name:

X

Date Created:

Date:_____

Are you under a physician's care now? Yes No	Have you ever been hospitalized or had a major operation? Ves No If yes Have you ever had a serious head or neck injury? Ves No If yes Are you taken, pre-Fen or Reduz? Ves No If yes Do you take, or have you taken, pre-Fen or Reduz? Ves No If yes Medication containing bisphosphorates? Are you are taken Foraman, Boilly, actional or any other medications containing bisphosphorates? Ves No Reduction Containing bisphosphorates? Ves No No Do you use controlled substances? Ves No No Do you use controlled substances? Ves No No Presidilin Despensional die? Ves No No Presidilin Despensional die										
Have you ever been hospitalized or had a major operation? Yes No If yes	Have you ever been hospitalized or had a major operation? Yes No Ef yes	Although dental personnel p	rimarily trea	at the are	a in and around your mou	th, your mo	uth is a pa	rt of your entire body. Hea	alth problems that	ou may have, or medication that	you may be t
Have you ever had a serious head or neck injury?	Nave you sever had a serious head or neck injury? Ves No If yes De you take, or have you taken, Prien-Fen or Redula? Ves No If yes De you take, or have you taken, Prien-Fen or Redula? Ves No If yes New You on a special diet? Ves No Do you se controlled substances? Ves No Do you use controlled substances? Ves No Do	Are you under a physician's	s care now	?	○Yes	○No	If yes				
Are you taken, prints, or drugs? Yes No If yes Do you take, or have you taken, Phen-Fin or Reduc? Yes No If yes If yes Are you on a special diet? Yes No Do you use controlled substances? Yes No If yes Do you use controlled substances? Yes No If yes Pendillin	Are you taking any medications, pills, or drugs?	Have you ever been hospit	alized or ha	ad a majo	or operation? O Yes	○No	If yes				
Do you take, or have you taken, Phen-Fen or Redux?	Do you take, or have you taken, Phen-Fen or Redux? Or you taken, or have you taken, Seanwa, Seanwa, Actonel or any other or Yes O No If yes Are you on a special diet? Or you use tobacco? Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances? Or yes O No If yes Or you was econtrolled substances?	Have you ever had a serio	us head or	neck inju	ıry? OYes	○No	If yes				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes Or you use to bacco? Yes No If yes Or you use controlled substances? Yes No If yes Or you use controlled substances? Yes No If yes Or you use controlled substances? Yes No If yes Or you use controlled substances? Yes No If yes Or you allerge to any of the following? Appin Penicillin Codeine Acrylic Aspin Latex Sulfa Drugs Local Anesthetics Other? If yes Or you have, or have you had, any of the following? Albrimer's Disease Yes Ono Diabetes Yes Ono Diabetes Yes Ono Negrial Diabetes Yes	Have you ever taken Fosamas, Boniva, Actonel or any other medications containing bisphosphoreads? Ves No Do you use tobacco? Ves No Dif yes Coment Are you PregnantTrying to get pregnant? Ponicillin Codeine Acrylic	Are you taking any medicat	ions, pills,	or drugs	?	○No	If yes				
Have you one as packed in Foatamas, Barniva, Actanel or any other medications containing bisphosphonater? Are you on a special diet? Or you use controlled substances? Or yes ONo Or yes On	Heave stow ever taken Floamans, Cloriva, Actonel or any other of Ne Over One a packed dide? Are you on a spacial dide? Or you use controlled substances? Or yes O No Or you use controlled substances? Or yes O No Or you use controlled substances? Or yes O No Or yes O No If yes Or yes O No Or ye	Do you take, or have you t	aken, Phen	-Fen or F	Redux? O Yes	○ No	If yes				
Are you une a special diet? Yes No No If yes No If yes No No If yes No No No No No Normer: Are you Pregnant/Trying to get pregnant?	Are you on a special diet? Yes No No Or you use to bacco? Yes No Or you use to bacco? Yes No Or you use controlled substances? Yes No Texture of the following? Taking or al contraceptives? T					_					
Do you use tobacco?	Do you use to bacco? Yes No If yes		phosphona	ates?	Over	∩ No					
Do you use controlled substances? Yes No If yes	Do you use controlled substances? O Yes O No If yes Omen: Are you Pregnant/Trying to get pregnant?										
comen: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?	men: Are you Pregnant? Nursing? Taking oral contraceptives?		tances?				If ves				
Pregnant/Trying to get pregnant?	Pregnant/Trying to get pregnant?	,			Oles	ONO	II yes				
e you allergic to any of the following? Aspirin	e you allergic to any of the following? Aspirin										
Aspirin	Aspirin	Pregnant/Trying to get p	oregnant?		Nursi	ng?			Taking o	ral contraceptives?	
Metal	Deter Dete	e you allergic to any of the	following?								
Other?	Other?	Aspirin			Penicillin			Codeine		Acrylic	
you have, or have you had, any of the following? AIDS/HIV Positive	Authority Court (and the court of the following)? AIDS/HIV Positive	Metal			Latex			Sulfa Drugs		Local Anesthetics	
AIDS/HIV Positive	AIDS/HIV Positive	Other?					If yes				
AIDS/HIV Positive	Alzheimer's Disease	you have, or have you hav	d, any of th	ne followin	10?						
Alzheimer's Disease	Alzheimer's Disease		_	_	-	○ Yes	○ No	Hemophilia	○Yes ○No	Radiation Treatments	○ Yes ○
Anemia	Anemia	Alzheimer's Disease	○Yes(○No	Diabetes	○ Yes	○ No	Hepatitis A	○Yes ○No	Recent WeightLoss	○Yes ○
Angina	Angina	Anaphylaxis	○Yes(○No	Drug Addiction	○ Yes	○ No	Hepatitis B or C	○Yes ○No	Renal Dialysis	○Yes ○
Arthritis/Gout	Arthritis/Gout	Anemia	○Yes(○ No	Easily Winded	○Yes	○No	Herpes	○Yes ○No	Rheumatic Fever	○Yes ○
Artificial HeartValve	Artificial Heart Valve	Angina	○Yes(○No	Emphysema	○ Yes	○No	High Blood Pressure	○Yes ○No	Rheumatism	○Yes ○
Artificial Joint	Artificial Joint	Arthritis/Gout	○Yes(○No	Epilepsy or Seizures	○ Yes	○No	High Cholesterol	○Yes ○No	Scarlet Fever	○Yes ○
Asthma	Asthma	Artificial Heart Valve	○Yes(○No	Excessive Bleeding	○ Yes	○No	Hives or Rash	○Yes ○No	Shingles	○ Yes ○
Blood Disease	Blood Disease	Artificial Joint	○Yes(○No	Excessive Thirst	○ Yes	○No	Hypoglycemia	○Yes ○No	Sickle Cell Disease	○Yes ○
Blood Transfusion	Blood Transfusion	Asthma	○Yes(○No	Fainting Spells/Dizziness	○ Yes	○No	Irregular Heartbeat	○Yes ○No	Sinus Trouble	○Yes ○
Breathing Problems	Breathing Problems	Blood Disease	○Yes(○No	Frequent Cough	○ Yes	○No	Kidney Problems	○Yes ○No	Spina Bifida	○Yes ○
Bruise Easily	Bruise Easily	Blood Transfusion	○Yes(○No	Frequent Diarrhea	○ Yes	○No	Leukemia	○Yes ○No	Stomach/Intestinal Disease	○Yes ○
Cancer	Cancer	Breathing Problems	○Yes(○No	Frequent Headaches	○ Yes	○No	Liver Disease	○Yes ○No	Stroke	○Yes ○
Chemotherapy	Chemotherapy	Bruise Easily	○Yes(○No	Genital Herpes	○ Yes	○No	Low Blood Pressure	○Yes ○No	Swelling of Limbs	○ Yes ○
Chest Pains	Chest Pains	Cancer	○Yes(○No	Glaucoma	○ Yes	○No	Lung Disease	○Yes ○No	Thyroid Disease	○Yes ○
Cold Sores/Fever Blisters	Cold Sores/Fever Blisters	Chemotherapy	○Yes(○No	Hay Fever	○Yes	○No	Mitral Valve Prolapse	○Yes ○No	Tonsillitis	○Yes ○
Congenital Heart Disorder	Congenital Heart Disorder	Chest Pains	○Yes(○No	Heart Attack/Failure	○ Yes	○No	Osteoporosis	○Yes ○No	Tuberculosis	○Yes ○
Convulsions O Yes O No Heart Trouble/Disease O Yes O No Psychiatric Care O Yes O No Venereal Disease O Yes O	Convulsions	Cold Sores/Fever Blisters	○Yes(○No	Heart Murmur	○ Yes	○No	Pain in Jaw Joints	○Yes ○No	Tumors or Growths	○Yes ○
	Yellow Jaundice Yes On	Congenital Heart Disorder	○Yes(○No	Heart Pacemaker	○ Yes	○No	Parathyroid Disease	○Yes ○No	Ulcers	○Yes ○
Yellow Jaundice Yes O		Convulsions	○Yes(○No	Heart Trouble/Disease	○ Yes	○No	Psychiatric Care	○Yes ○No	Venereal Disease	○Yes ○
	Have you ever had any serious illness not listed above? Oyes ONo If yes									Yellow Jaundice	○Yes ○
	Have you ever had any serious illness not listed above? O Yes O No If yes	Convulsions	○Yes(○No	Heart Trouble/Disease	○ Yes	○No	Psychiatric Care	○Yes ○No		_
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	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 n	#- b t - 6 ! ! ! .	h		Form house h				-t :- f ··		landala err