

Eaglesoft Medical History - Kim Arrington(Copy)(Nov 2018)(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 you may be taking, could have an important interrelationship with the dentistry you will receive. This is for our records only and will be considered confidential. Thank you

Are you under a physician's care now or for the past 5 years? If yes, for what? Physician's name, address, and date of last physical Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Are you on a special diet? If yes, please explain. Are you taking any prescription medications? Please list. Are you taking any over-the-counter (OTC) medications, supplements, or herbal medications? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you taking any medications affect your immune system or healing? Do you consume alcohol? If yes, how many drinks per week? Tobacco use? If yes, how much and for how long? For former smokers only, how much and for how long? When did you quit?

Height _____ Weight _____ (necessary for accurate dosing of medications)

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Metal NSAIDs (Advil, Motrin, Aleve) Penicillin Latex Shellfish or Iodine Codeine Sulfa Drugs Tetracyclines Acrylic Local Anesthetics Clindamycin

Allergies to any other medications not listed above? Please list: Do you use controlled substances?

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

AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pacemaker Heart Trouble/Disease Sleep Apnea ADHD Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Bleeding/Clotting Problems Excessive Thirst Fainting Spells/Dizziness Frequent Cough Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Osteoporosis Pain in Jaw Joints Parathyroid Disease Psychiatric Care Neurologic Disorders Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure High Cholesterol Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Anxiety or Nervousness Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Blood Transfusion Breathing Problems Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Yellow Jaundice Parkinson's Disease

Have you ever had any serious illness not listed

Sedation History. Any Complications During Sedation? Other Comments:

[Empty box for Sedation History and Comments]

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. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Signature of Patient, Parent or Guardian:

X

Date: _____