Eaglesoft Medical History 2015 with dental(Copy)

Patient Name: Birth Date: Date Created:

Reason for today's visit

- Examination/Cleaning ☐
- Pain ☐
- Broken tooth/filling ☐
- Other ☐

Previous History at other dental offices

- Have you had dental x-rays in the last year? ◯ Yes ◯ No
- Have you had a full mouth series or the large panoramic x-ray in the last 5 years? ◯ Yes ◯ No
- Do you have concerns about previous dental ◯ Yes ◯ No
- How many times a year do you get your teeth

Check any of the following you have/had

- Are you apprehensive about dental treatment? ◯ Yes ◯ No
- Do your gums bleed? ◯ Yes ◯ No
- Have you been told you have gum disease? ◯ Yes ◯ No
- Do you floss daily? ◯ Yes ◯ No
- Are your teeth sensitive to hot, cold or sweets? ◯ Yes ◯ No
- Are you aware of grinding or clenching your teeth? ◯ Yes ◯ No
- Do you have jaw pain? ◯ Yes ◯ No
- Have you had orthodontics (braces)? ◯ Yes ◯ No
- Do you have cracked, chipped or discolored teeth that bother you? ◯ Yes ◯ No
- Do you like the color of your teeth? ◯ Yes ◯ No
- Do you drink soda pop, juices, sports drinks or energy drinks? ◯ Yes ◯ No
- Do you suck or chew mints, cough or sore throat drops or candies? ◯ Yes ◯ No
- Do you take chewable vitamins or calcium? ◯ Yes ◯ No
- Do you have dry mouth? ◯ Yes ◯ No
- How often do you brush your teeth?
- Are you happy with your smile? ◯ Yes ◯ No

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Do you have any current health problems? ◯ Yes ◯ No If yes
- Are you under the care of a physician now or a recent hospitalization? ◯ Yes ◯ No If yes
- Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes
- Are you taking any medications, pills,vtamins or ◯ Yes ◯ No If yes
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No If yes
- Do you use tobacco? ◯ Yes ◯ No
- Date of last physical examination

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

- Other? ☐ If yes
- Do you use controlled substances? ◯ Yes ◯ No If yes

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

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Anemia	◯ 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 Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excess Bleeding/ Bruising	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No
Sinus Trouble	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No

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

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.

Signature of Patient, Parent or Guardian:

X_____ Date:_____