Eaglesoft Medical History at Now Care Dental

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

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury? Please List.	Yes No	If yes
Are you taking any medications, pills, or drugs? Please List.	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

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

Are you allergic to any of the following?

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

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

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	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	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	Scarlet Fever	Yes No	Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No
Hives or Rash	Yes No	Shingles	Yes No	Artificial Joint	Yes No	Excessive Thirst	Yes No
Hypoglycemia	Yes No	Sickle Cell Disease	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Frequent Cough	Yes No
Kidney Problems	Yes No	Blood Transfusion	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No
Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No	Mitral Valve Prolapse	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No
Heart Pacemaker	Yes No	Ulcers	Yes No	Convulsions	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:_____