26TH STREET DENTAL CENTER **Eaglesoft Medical History**

Birth Date:

Patient Name: 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 Are you under a physician's care now? If yes OYes ONo Have you ever been hospitalized or had a major operation? OYes ONo If yes Have you ever had a serious head or neck injury? OYes ONo If yes Are you taking any medications, pills, or drugs? OYes ONo 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 OYes ONo If yes medications containing bisphosphonates? Are you on a special diet? OYes ONo Do you use tobacco? OYes ONo Do you use controlled substances? OYes ONo If yes Women: Are you... Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? Are you allergic to any of the following? Penicillin Acrylic Aspirin Codeine Latex Sulfa Drugs Local Anesthetics Metal Other? If yes Do you have, or have you had, any of the following? ○Yes ○No ○Yes ○No AIDS/HIV Positive OYes ONo Cortisone Medicine Hemophilia Radiation Treatments OYes ONo OYes ONo Alzheimer's Disease OYes ONo Diabetes Hepatitis A OYes ONo Recent Weight Loss OYes ONo OYes ONo Hepatitis B or C Renal Dialysis OYes ONo Anaphylaxis ○Yes ○No Drug Addiction OYes ONo Anemia OYes ONo Easily Winded ○Yes ○No Herpes OYes ONo Rheumatic Fever OYes ONo Angina ○Yes ○No Emphysema OYes ONo High Blood Pressure OYes ONo Rheumatism OYes ONo ○Yes ○No Arthritis/Gout OYes ONo Epilepsy or Seizures High Cholesterol OYes ONo Scarlet Fever OYes ONo Artificial Heart Valve OYes ONo Excessive Bleeding OYes ONo Hives or Rash OYes ONo Shingles OYes ONo Artificial Joint ○Yes ○No Excessive Thirst OYes ONo Hypoglycemia ○Yes ○No Sickle Cell Disease OYes ONo Fainting Spells/Dizziness Sinus Trouble Asthma OYes ONo OYes ONo Irregular Heartbeat OYes ONo OYes ONo Spina Bifida Blood Disease OYes ONo Frequent Cough OYes ONo Kidney Problems OYes ONo OYes ONo OYes ONo Blood Transfusion OYes ONo Frequent Diarrhea Leukemia OYes ONo Stomach/Intestinal Disease OYes ONo Breathing Problems ○Yes ○No Frequent Headaches OYes ONo Liver Disease ○Yes ○No Stroke OYes ONo OYes ONo Bruise Easily Genital Herpes OYes ONo Low Blood Pressure Swelling of Limbs OYes ONo ○Yes ○No OYes ONo Lung Disease Thyroid Disease OYes ONo Cancer OYes ONo Glaucoma O Yes O No OYes ONo Mitral Valve Prolapse Tonsillitis Chemotherapy OYes ONo Hay Fever OYes ONo OYes ONo Chest Pains Tuberculosis OYes ONo Heart Attack/Failure OYes ONo Osteoporosis OYes ONo OYes ONo Cold Sores/Fever Blisters OYes ONo Heart Murmur OYes ONo Pain in Jaw Joints OYes ONo Tumors or Growths OYes ONo Congenital Heart Disorder OYes ONo Heart Pacemaker ○Yes ○No Parathyroid Disease ○Yes ○No OYes ONo Convulsions Heart Trouble/Disease ○Yes ○No Psychiatric Care ○Yes ○No ○Yes ○No ○Yes ○No Venereal Disease Yellow Jaundice ○Yes ○No Have you ever had any serious illness not listed above? OYes ONo If ves 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: