Eaglesoft Medical History

Patient Name:

Birth Date:

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

Date Created:

Any you under a physication score nov? If yes no operations of the control of the control operations of the control operat	medication that you may be taking, could	nave an important inten	elacionship with t	are dericibly you will rec	eive. Illalik you	Tot allowering the following	y quescions.	
operation? Now you were had a senous head or neck injury? Ves No If ves Do you take, or have you taken, Phen-Fen or Redux? Ves No If ves Are you are a special det? Obyou use tebesco? Now you serve taken Fosia, Saneta, Aredia, Avastin Ves No If ves Now you were taken Fosia, Saneta, Aredia, Avastin Ves No If ves Women: Are you. Reclador or any other bisphosphonates? Nomen: Are you. Reclador or any other bisphosphosphosphosphosphosphosphosphospho	Are you under a physician's care now?	⊚ Yes ⊚	No If yes					
Have you even fad a serious head or neck injury?		a major 🔘 Yes 🌘	No If yes					
Do you take, or have you taken, Phen Fen or Reduz? Are you an a special dete? Yes No Yes No	' '	ck injury? Yes) No If yes					
Are you on a special diet? Ves No Abchimer's Disease Ves No Anaphyloxs Ves No Blood Disease Ves No Conversion No Recent Very Ne No No Conversion Ne No Recent Very Ne No No Conversion Ne No No Conversion Ne No Conversion Ne No No Conversion Ne No No Conversion Ne No No No Conversion Ne No N	Are you taking any medications, pills, or	drugs?	No If yes					
Do you use tabacco? Have you ever taken Frolia, Zometa, Aradia, Avastin Yes No If yes	Do you take, or have you taken, Phen-Fen or Redux?		No If yes					
Do you use tabacco? Have you ever taken Frolia, Zometa, Aradia, Avastin Yes No If yes								
Here you ever taken Prolio. Zometa, Aredia, Avestin or any other bisphosphometes? Women: Are you Pregnant/Trying to get pregnant?	· ·							
or any other bisphosphonates? Women: Are you Women: Are you Are you allergic to any of the following? Aspirin Metal Do you use controlled substances? Other? Pennanty of the following? Aspirin Metal Do you use controlled substances? Other? If yes Sleep Apnea Screen Do you sonce? Do you sonce? Oy so have unrefreshed sleep? How witnessed apnea with sleep? Orange of the witnessed apnea wi								
Women: Are you Prepanart/Trying to get pregnant?			No II yes					
Pregnant/Trying to get pregnant?			No If yes					
Are you alergic to any of the following? Aspirin	Women: Are you							
Aspirin	Pregnant/Trying to get pregnant?	Nursing	?		Taking or	al contraceptives?		
Metal	Are you allergic to any of the following?							
Do you use controlled substances? Other? Sleep Apnea Screen Do you snore? Other Yes No Do you snore? Yes No Do you snore? Yes No Do you wish to discuss other options of Obstructive Yes No Do you wish to discuss other options of Obstructive Yes No Albiemer's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anthritis/Gout Anthritis/Gout Yes No Artificial Heart Valve Yes No Blood Disease Yes No Bruss Easily Yes No Bruss Easily Yes No Glaucoms Anaphylaxis Yes No Chemotherapy Yes No Congental Herr Diserde Yes No Heart Attack/Failure Yes No Congental Herr Diserde Yes No Heart Attack/Failure Yes No Congental Herr Diserde Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease								
Sleep Apnea Screen	Metal	Latex		Sulta Drugs		Local Anesthetics		
Sleep Apnea Screen Do you snore? Do you have unrefreshed sleep? Have witnessed apnea with sleep? Current CPAP user? Current CPAP user? Do you wish to discuss other options of Obstructive	Do you use controlled substances?	Yes	No If yes					
Do you have unrefreshed sleep?	Other?		If yes					
Do you have unrefreshed sleep?	Sleen Annes Screen							
Do you have unrefreshed sleep? Have witnessed apnea with sleep? CUrrent CPAP user? CPAP intolerance? Do you wish to discuss other options of Obstructive Sleep Apnea? Do you have, or have you had, any of the following? AIDS/HIV Positive Albs/Hird's Disease Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Angina Yes No Angina Yes No Artificial Joint Artificial Joint Yes No Artificial Heart Valve Yes No Blood Disease Yes No Blood Disease Yes No Blood Transfusion Sireathing Problems Yes No Brusise Easily Yes No Brusise Easily Yes No Central Herpes Yes No Central Herpes Yes No Congental Heart Disorder Yes No Congental Heart Disorder Yes No Heart Matcol/Failure Yes No Congental Heart Disorder Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Partity Journal of Yes No Congental Heart Disorder Yes No Congental Heart Disorder Yes No Congental Heart Disorder Yes No Heart Trouble/Disease Yes No Partity Journal of Yes No Congental Heart Disorder Yes No Heart Trouble/Disease Yes No Heart Trouble/Disease Yes No Partity Journal of Yes No Heart Trouble/Disease Yes No Congental Heart Disorder Yes No Congental Heart Disorder Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Congental Heart Disorder Yes No Heart Trouble/Disease Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Partity Journal of Yes No Partity Journal of Yes No Partity Journal of Yes No Heart Marcol/Failure Yes No Partity Journal of Yes N			∋ No					
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Do you wish to discuss other options of Obstructive Yes No Sleep Apnea? Do you have, or have you had, any of the following? AIDS/HIV Positive Yes No Diabetes Yes No Alzheimer's Disease Yes No Anaphylaxis Yes No Arthritis/Gout Yes No Arthritis/Gout Yes No Emphysema Yes No Epilepsy or Seizures Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Blood Disease Yes No Blood Disease Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problems Yes No Breathing Problems Yes No Cancer Yes No Glaucoma Harpes Yes No Chemotherapy Yes No Chemotherapy Yes No Congential Heart Disorder Yes No Convulsions Yes No Convulsions Yes No No Convulsions Yes No No Yellow Jaundice Yes No Hard Murmur Yes No Convulsions Yes No Hart Trouble/Disease Yes No Ye								
Do you have, or have you had, any of the following?								
AIDS/HIV Positive								
Alzheimer's Disease		_				ı		
Anaphylaxis								
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Arthritis/Gout		_	Yes No		Yes No		Yes No	
Artificial Heart Valve	7 g			_				
Artificial Joint Yes No Ashma Yes No Ashma Yes No Blood Disease Yes No Blood Disease Yes No Blood Disease Yes No Blood Transfusion Yes No Breathing Problems Yes No Bruise Easily Yes No Cancer Yes No Chemotherapy Yes No Chest Pains Yes No Congenital Heart Disorder Yes No Convulsions Yes No Convulsions Yes No Have you ever had any serious illness not listed Yes No Iso Ashma Yes No Iso Restance Yes No Iso				_				
Asthma						_		
Blood Transfusion							_	
Breathing Problems Yes No Bruise Easily Yes No Genital Herpes Yes No Genital Herpes Yes No Cancer Yes No Chemotherapy Yes No Chemotherapy Yes No Cold Sores/Fever Blisters Yes No Congenital Heart Disorder Yes No Yellow Jaundice Yes No Heart Trouble/Disease Yes No Yellow Jaundice Yes No Have you ever had any serious illness not listed Yes No If yes To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dental office of any changes in medical status. Frequent Headaches Yes No Low Blood Pressure Yes No Hitral Valve Prolapse Yes No Ungrid Disease Yes No Thyroid Disease Yes No Thyroid Disease Yes No Thyroid Disease Yes No Understand Disease Yes No Venereal Disease Yes No No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No Venereal Disease Yes No No Venereal Disease Yes No No							_	
Bruise Easily								
Cancer							_	
Chest Pains		•				_	_	
Cold Sores/Fever Blisters		•						
Congenital Heart Disorder							_	
Convulsions	,							
Have you ever had any serious illness not listed Yes No If yes 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.								
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X Date:	X				Da	ate:		