Integrated Dental Aesthetics

Eaglesoft Medical History Corrected

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

Question	Answer	
Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized, had a major operation or had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills or drugs?	Yes No	If yes
Are you taking or have ever taken antii anxiety medication?	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	

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

Question	Answer	
Do you use controlled substances?	Yes No	If yes
Other?		If yes

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

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Alzheimer's Disease	Yes No
Diabetes	Yes No	Recent Weight Loss	Yes No	Anaphylaxis	Yes No	Drug Addiction	Yes No
Hepatitis A, B or C	Yes No	Renal Dialysis	Yes No	Anemia	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High/Low 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	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	Liver Disease	Yes No
Stroke	Yes No	Bruise Easily	Yes No	Swelling of Limbs	Yes No	Cancer	Yes No
Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No	Chemotherapy	Yes No
Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Chest Pains	Yes No	Heart Attack/Failure	Yes No
Osteoporosis	Yes No	Tuberculosis	Yes No	Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No
Tumors or Growths	Yes No	Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	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 above? Yes No If yes

Do you have any of the following?

Headaches	Dizziness	Grinding	Jaw Pain
Facial Pain	Jaw Popping	Posture Problems	Limited Opening
Clenching	Congested Ears	Ringing Ears	Neck Ache

Circle if you have seen: ENT, Neurologist, Chiropractor, had bite related therapy, had TMJ joint surgery.

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:__________