Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Date:____

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Although dental person medication that you ma	nel primarily treat y be taking, coul	the area in and around y d have an important inter	our mour relations	th, your i	mouth is a part of your e he dentistry you will rec	entire body. Hea eive. Thank you	Ith problems that you may for answering the followin	have, or g questions.
Are you under a physic	ian's care now?	Yes	○ No	If yes		***************************************		
Have you ever been hospitalized or had a major			⊕ No	If yes				
operation? Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs?		eck injury? Yes	○ No	If yes				
		r drugs? O Yes		If yes				
Do you take, or have yo		-) No	If yes				
		_						
	Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?) No	If yes				
Are you on a special di	et?	Yes	⊚ No					
Do you use tobacco?		Yes	No					
Women: Are you								
Pregnant/Trying to	get pregnant?	Nursin	g?			Taking or	al contraceptives?	
Are you allergic to any of	the following?							
Aspirin		Penicillin			Codeine		Acrylic	
Metal		Latex			Sulfa Drugs		Local Anesthetics	
Other?				If ves				
Do you use controlled s	substances?	Yes	⊗ No	If ves				
Do you have, or have you AIDS/HIV Positive	Yes No	T	Yes	€ No		Nos A No	D-disting Tourish	∨oc No
Alzheimer's Disease	Yes No	Cortisone Medicine Diabetes	© Yes		Hemophilia	Yes No	Radiation Treatments	Yes No
	Yes No				Hepatitis A	Yes No	Recent Weight Loss	O Yes O No
Anaphylaxis	Yes No	Drug Addiction	O Yes		Hepatitis B or C	Yes No	Renal Dialysis	○ Yes ○ No
Anemia		Easily Winded	⊚ Yes		Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	O Yes	_	High Blood Pressure	O Yes O No	Rheumatism	⊕ Yes ⊕ No
Arthritis/Gout	Yes No	Epilepsy or Seizures	O Yes		High Cholesterol	O Yes O No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	Yes No	Excessive Bleeding	O Yes		Hives or Rash	O Yes O No	Shingles	⊕ Yes ⊕ No
Artificial Joint	Yes No	Excessive Thirst	Yes		Hypoglycemia	Yes No	Sickle Cell Disease	○ Yes ○ No
Asthma	Yes No	Fainting Spells/Dizziness		-	Irregular Heartbeat	O Yes O No	Sinus Trouble	○ Yes ○ No
Blood Disease	Yes No	Frequent Cough	Yes		Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	O Yes O No	Frequent Diarrhea	Yes		Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes		Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes		Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	O Yes O No	Glaucoma	Yes	○ No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes	○ No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes
Chest Pains	Yes No	Heart Attack/Failure	Yes	⊘ No	Osteoporosis	Yes No	Tuberculosis	Yes
Cold Sores/Fever Blister		Heart Murmur	Yes	○ No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes	⊗ No	Parathyroid Disease	Yes No	Ulcers	O Yes O No
Convulsions	Yes No	Heart Trouble/Disease	Yes	⊚ No	Psychiatric Care	Yes No	Venereal Disease Yellow Jaundice	Yes No
Have you ever had any	serious illness n	ot listed	no No	If yes			Tellow Sadilates	
				- ,	*			
Comments:								
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First Name	ID:	Chart ID:				
Responsible Parry (if someone other than the patient)	First Name:		Last Name:			Middle Initial:
First Name	Patient Is: Policy Holder	Responsible Party	Preferred Name:			
Address: Address Pager	Responsible Party (if so	meone other than the patient) —				
City, State, Zip:	First Name:		Last Name:			Middle Initial:
Home	Address:		Address	s 2:		
Birth Date: Soc Sec: Drivers Lie: Responsible Party is also a Policy Holder for Patient	City, State, Zip:					Pager:
Responsible Party is also a Policy Holder for Patient		Work Phone:			Ext:	Cellular:
Patient Information		Soc Sec:			Drive	rs Lie:
Address: State / Zip: Pager: Home Phone: Work Phone: Ext: Celtular: Phone: Work Phone: Ext: Celtular: Sex:Male	Responsible Party is also a	Policy Holder for Patient	Primary Insurance	Policy Holder		Secondary Insurance Policy Holder
City:	Patient Information —					
Home	Address:		Address	3 2:		
Phone:	City:		State / Zip:			Pager:
Sex: Male Female Marital Status: Married Single Divorced Separated Widowed		Work Phone:			Ext:	Cellular:
E-mail: I would like to receive correspondences via e-mail. Section 2		Female	Marital Status:	Married Single	Divorced	Separated Widowed
Section 2	Birth Date:	Age:	Soc	Sec:	Driver	rs Lie:
Employment	E-mail:			I would like to receive	correspondences v	ia e-mail.
Status: Full Time		Section 2				Section 3
Student Status: Full Time	Employment Full Tir	ne Part Time	Retired			
Medicaid ID: Pref. Dentist: Emergency Contact # Employer ID: Pref. Pharmacy: Carrier ID: Pref. Hyg: Primary Insurance Information Relationship to Insured: Self Spouse Child Other Insured Soc. Sec: Insured Birth Date: Relationship to Insured: Self Spouse Child Other Employer: Address: Address: Address 2: Address 2: Insured Sec. Sec: Secondary Insurance Information Secondary Insurance Information Rem. Deduct: Self Spouse Child Other Name of Insured: Relationship to Insured: Self Spouse Child Other Other Insured Soc. Sec: Insured Birth Date: Ins. Company: Address: Address: Address: Address: Address: Address: Address: Address: Insured Sec. Sec. Sec. Sec. Sec. Sec. Sec. Sec.		ne Part Time		3	Emer	
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