Riverside Dentistry, LLC **Eaglesoft Medical History**

Date Created:

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 medication that you may be taking, c Are you under a physician's care now? 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? Yes
No If yes Are you taking any medications, pills, or drugs? 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 If yes Yes
No medications containing bisphosphonates? Are you on a special diet? Yes
No Do you use tobacco? Yes
No Do you use controlled substances? Yes
No If yes Women: Are vou... 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 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 Renal Dialysis Anaphylaxis Yes
No Drug Addiction Yes No Hepatitis B or C Yes
No Yes
No Anemia Yes
No Easily Winded Yes No Herpes Yes
No Rheumatic Fever Yes
No Angina Yes
No Emphysema High 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 Excessive Thirst Hypoglycemia Sickle Cell Disease Yes No O Yes O No Yes
 No Yes
No Asthma Yes No Fainting Spells/Dizziness Yes
No Irregular Heartbeat O Yes No Sinus Trouble Yes
No Blood Disease Frequent Cough Yes
No Kidney Problems Spina Bifida Yes
No Yes
No Blood Transfusion Frequent Diarrhea Yes No Leukemia Stomach/Intestinal Disease Yes
 No Yes
No O Yes O No Breathing Problems Frequent Headaches Liver Disease Yes No Yes
No O Yes No Stroke Yes
No Genital Herpes Swelling of Limbs Bruise Easily Yes No Low Blood Pressure Yes
No Yes
No Yes
No Cancer Yes
No Glaucoma Yes
No Lung Disease Yes
No Thyroid Disease Yes
No Mitral Valve Prolapse Tonsillitis Chemotherapy Yes
No Hay Fever Yes
No Yes
No 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 Pain in Jaw Joints Yes
No Tumors or Growths Yes
No Congenital Heart Disorder Yes
No Heart Pacemaker Yes No Parathyroid Disease O Yes No Ulcers Yes No Heart Trouble/Disease Convulsions Yes
No Yes No Psychiatric Care O Yes No Venereal Disease Yes
No Yellow Jaundice Yes No Have you ever had any serious illness not listed above? If ves Yes
No 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: