Time 4:48 PM

Pilager Dental

Date 2/6/2019

Eaglesoft Medical History 2019-A

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.

Do you have a Primary Physician?	Yes No	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
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 medications containing bisphosphonates?	Yes No	If yes
Do you use street/illegal drugs?	Yes No	If yes
Are you taking any medications, pills, drugs or vitamins?	Yes No	

Please list ALL Medications:

Are you allergic to any of the following:

Acrylic	Yes No	
Aspirin	Yes No	
Codeine	Yes No	
Latex	Yes No	
Local Anesthetic	Yes No	
Metal	Yes No	
Penicillin	Yes No	
Sulfa Drugs	Yes No	
Other	Yes No	If yes

Do you use Tobacco? If so, select:

Cigarettes/Cigars	Yes No
Chewing Tobacco	Yes No
E-Cigarettes	Yes No
Vape	Yes No

Women: Are you...

☐ Pregnant ☐ Nursing? ☐ Taking oral contraceptives?

☐ Trying to get pregnant?

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

AIDS/HIV positive	Yes No	Congenital Heart Disease	Yes No	Hemophilia	Yes No	Parathyroid Disease	Yes No
Alzheimer's Disease	Yes No	Cortisone Medicine	Yes No	Hepatitis	Yes No	Psychiatric Care	Yes No
Anaphylaxis	Yes No	Depression/Anxiety	Yes No	Herpes	Yes No	Radiation Treatment	Yes No
Anemia	Yes No	Diabetes	Yes No	High Blood Pressure	Yes No	Renal Dialysis	Yes No
Arthritis/Gout	Yes No	Drug Addiction	Yes No	High Cholesterol	Yes No	Shingles	Yes No
Artificial Heart Valve	Yes No	Emphysema	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Artificial Joint	Yes No	Epilepsy/Seizures	Yes No	Insulin Pump	Yes No	Sinus Trouble	Yes No
Asthma	Yes No	Excessive Bleeding	Yes No	Irregular Heartbeat	Yes No	Stomach/Intestinal Disease	Yes No
Autism/Aspergers	Yes No	Fainting Spells/Dizziness	Yes No	Kidney Problems	Yes No	Stroke	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Swelling of Limbs	Yes No
Bruise Easily	Yes No	Glaucoma	Yes No	Liver Disease	Yes No	Thyroid Disease	Yes No
Cancer	Yes No	Heart Attack/Failure	Yes No	Low Blood Pressure	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Heart Murmur	Yes No	Lung Disease	Yes No	Tumors/Growths	Yes No
Chest Pain	Yes No	Heart Pacemaker	Yes No	Mitral Valve Proplapse	Yes No	Ulcers	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Trouble/Disease	Yes No	Osteoporosis	Yes No		

Have you ever had any serious illness/disease not listed above? 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.

Signature of Patient, Parent or Guardian:

X Date:_____