## Madison Family Dental Prof LLC Eaglesoft Medical History with signature (Copy) Birth Date: Date Created:

Patient Name:

| Do you have a primary care physician  |  |                         |                      |  |                |  |
|---|--|-------------------------|----------------------|--|----------------|--|
| and phone number:   | n? Please list their name  | O Yes                   | O No                 | If yes   |                |  |
| Are you currently being seen by a sp<br>medical treatment (heart, orthopedic  |  | O Yes                   | O No                 | If yes   |                |  |
| Have you ever been hospitalized or had a major operation?  Have you ever had a serious head or neck injury?  Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other medications for osteoporosis?  Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew)?  |  | O Yes                   | No No No No No       | If yes   |                |  |
|   |  |                         |                      | If yes   |                |  |
|   |  |                         |                      | If yes   |                |  |
|   |  |                         |                      | If yes   |                |  |
| Do you use vaping products?  Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?  Have you ever been told you need an antibiotic premedication prior to dental work?   |  | O Yes                   | O No                 | If yes   |                |  |
|   |  | O Yes                   | ○ No                 | If yes   |                |  |
|   |  | O Yes                   |                      | If yes   |                |  |
| Are you taking any medications, pills, o  | or drugs? Please list all medic  | ations                  |                      |  |                |  |
|   |  |                         |                      |  |                |  |
| Vener only Are year   |  |                         |                      |  |                |  |
| Vomen only: Are you:  | - n.   | 2                       |                      |  | PR + 11        |  |
| Pregnant Nursing Trying to get Pregnant   |  | 9                       |                      |  | Takir          | ng oral contraceptives   |
| Are you allergic to any of the following  | ?  |                         |                      |  |                |  |
| Aspirin   | Penicillin   |                         |                      | Codeine  |                | Acrylic  |
| Metal   | Latex  |                         |                      | Sulfa Drugs  |                | Local Anesthetics  |
|   |  |                         |                      |  |                |  |
| United States of the Control of the | III LOVE   |                         | 0.5                  | - Dana Drags   |                | cocal Allesa Coca  |
| Peanuts   |  |                         | 9.5                  | Dana Brags   |                |  |
|   |  | O Yes                   | O No                 | If yes   |                | coca ancade  |
| Peanuts   |  | O Yes                   |                      |  |                | cocar an estate esta   |
| Peanuts  Do you have any other allergies?   |  | 0=000                   | O No                 | If yes   |                |  |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?   |  | O Yes                   | O No<br>O No         | If yes   |                |  |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep   | apnea?   | O Yes                   | O No<br>O No<br>O No | If yes  If yes  If yes   |                |  |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?   | apnea?<br>told you should have a   | O Yes Yes Yes           | O No<br>O No<br>O No | If yes  If yes  If yes  If yes   |                |  |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?  Do you have, or have you had, any of   | apnea?  told you should have a.  the following?  | O Yes Yes Yes           | O No<br>O No<br>O No | If yes  If yes  If yes  If yes  If yes   |                |  |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?  Oo you have, or have you had, any of   | apnea?  told you should have a  the following?  Cortisone Medicine   | O Yes Yes Yes           | O No<br>O No<br>O No | If yes  If yes  If yes  If yes  If yes  High Cholesterol   |                | Radiation Treatments   |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?  Do you have, or have you had, any of Acid Reflux/GERD  Afbrilation   | told you should have a  the following?  Cortisone Medicine Diabetes  | O Yes Yes Yes           | O No<br>O No<br>O No | If yes  If yes  If yes  If yes  If yes  High Cholesterol  Hives or Rash  |                | Radiation Treatments Recent Weight Loss  |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?  Do you have, or have you had, any of Acid Reflux/GERD  Afibrilation  AIDS/HIV Positive   | told you should have a  the following?  Cortisone Medicine Diabetes Emphysema  | O Yes O Yes O Yes O Yes | O No<br>O No<br>O No | If yes  If yes  If yes  If yes  If yes  If yes  High Cholesterol  Hives or Rash  Hypoglycemia  |                | Radiation Treatments Recent Weight Loss Renal Dialysis   |
| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?  Do you have, or have you had, any of  Acid Reflux/GERD  Afibrilation  AIDS/HIV Positive  Alzheimer's Disease   | told you should have a  the following?  Cortisone Medicine Diabetes Emphysema Epilepsy or Seizures   | O Yes O Yes O Yes O Yes | O No<br>O No<br>O No | If yes  If yes  If yes  If yes  If yes  If yes  High Cholesterol  Hives or Rash  Hypoglycemia  Irregular Heartbe   | eat            | Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatism  |
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| Peanuts  Do you have any other allergies?  Have you ever been told you snore?  Have you been diagnosed with sleep  Do you have a CPAP?  Have you had a sleep study or been sleep study?  Do you have, or have you had, any of  Acid Reflux/GERD  Afibrilation  AIDS/HIV Positive  Alzheimer's Disease  Anaphylaxis  Anemia  Arthritis/Gout  Artificial Heart Valve  | told you should have a  the following?  Cortisone Medicine Diabetes Emphysema Epilepsy or Seizures Excessive Bleeding Fainting Spells/Dizzir Frequent Cough Frequent Headaches   | O Yes O Yes O Yes O Yes | O No<br>O No<br>O No | If yes  An  |                | Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatism Shingles Sickle Cell Disease Sinus Trouble Spina Bifida  |
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| Signature of Patient, Parent or Guardian: |       |
|---|-------|
|   |       |
|   |       |
| X   | Date: |