Eaglesoft Medical History with signature (Copy)

Patient Name: Birth Date: Date Created:

Please answer the following questions:

Do you have a primary care physician? Please list their name and phone number:	○ Yes ○ No	If yes	
Are you currently being seen by a specialist for any specific medical treatment (heart, orthopedics, etc)? Please list:	○ 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	
Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other medications for osteoporosis?	○ Yes ○ No	If yes	
Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew)?	○ Yes ○ No	If yes	
Do you use vaping products?	○ Yes ○ No	If yes	
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?	○ Yes ○ No	If yes	
Have you ever been told you need an antibiotic premedication prior to dental work?	○ Yes ○ No	If yes	

Are you taking any medications, pills, or drugs? Please list all medications

Women only: Are you:

☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives
☐ Trying to get Pregnant

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts			

Do you have any other allergies?	○ Yes ○ No	If yes	

Have you ever been told you snore?	○ Yes ○ No	If yes	
Have you been diagnosed with sleep apnea?	○ Yes ○ No	If yes	
Do you have a CPAP?	○ Yes ○ No	If yes	
Have you had a sleep study or been told you should have a sleep study?	○ Yes ○ No	If yes	

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

☐ Acid Reflux/GERD	☐ Cortisone Medicine	☐ High Cholesterol	☐ Radiation Treatments
☐ Afibrilation	☐ Diabetes	☐ Hives or Rash	☐ Recent Weight Loss
☐ AIDS/HIV Positive	☐ Emphysema	☐ Hypoglycemia	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Epilepsy or Seizures	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Excessive Bleeding	☐ Jaundice	☐ Shingles
☐ Anemia	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Frequent Cough	☐ Leukemia	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Frequent Headaches	☐ Liver Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Glaucoma	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Heart Attack/Failure	☐ Lung Disease	☐ Stroke
☐ Autism	☐ Heart Murmur	☐ Mitral Valve Prolapse	☐ Swelling of Limbs
☐ Blood Disease	☐ Heart Pacemaker	☐ Multiple Sclerosis	☐ Thyroid Disease
☐ Breathing Problems	☐ Heart Trouble/Disease	☐ Organ Transplant	☐ Tonsillitis
☐ Cancer	☐ Hemophilia	☐ Osteoporosis	☐ Tuberculosis
☐ Chemotherapy	☐ Hepatitis A, B or C	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Chest Pains	☐ Herpes	☐ Parathyroid Disease	☐ Ulcers
☐ Cold Sores/Fever Blisters	☐ High Blood Pressure	☐ Psychiatric Care	☐ Vertigo
☐ Congenital Heart Disorder			

Have you ever had any serious illness not listed above?	○ Yes ○ No	If yes	

Signature of Patient, Parent or Guardian:

X Date:_____