Patient Name:

## Flex Dental Eaglesoft Medical History

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, c Are you under a physician's care now? OYes ONo If ves Have you ever been hospitalized or had a major operation? OYes ONo If yes Have you ever had a serious head or neck injury? OYes ONo If yes Are you taking any medications, pills, or drugs? OYes ONo If yes Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If yes Have you ever taken Fosamax, Boniva, Actonel or any other OYes ONo If yes medications containing bisphosphonates? Are you on a special diet? OYes ONo Do you use tobacco? OYes ONo Do you use controlled substances? OYes ONo If yes Women: Are you... 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 Mediane OYes ONo Hemophilia OYes ONo Radiation Treatments OYes ONo Alzheimer's Disease OYes ONo Diabetes ○Yes ○No Hepatitis A OYes ONo Recent Weight Loss OYes ONo Anaphylaxis OYes ONo Drug Addiction OYes ONo Hepatitis B or C OYes ONo Renal Dialysis OYes ONo Anemia OYes ONo Easily Winded OYes ONo OYes ONo Rheumatic Fever OYes ONo Angina ○Yes ○No Emphysema High Blood Pressure OYes ONo OYes ONo Rheumatism OYes ONo Arthritis/Gout OYes ONo Epilepsy or Seizures OYes ONo High Cholesterol OYes ONo Scarlet Fever OYes ONo Artificial Heart Valve OYes ONo Excessive Bleeding OYes ONo Hives or Rash OYes ONo Shingles OYes ONo Artificial Joint OYes ONo Excessive Thirst OYes ONo Hypoglycemia O Yes O No Sickle Cell Disease OYes ONo Asthma OYes ONo Fainting Spells/Dizziness OYes ONo Irregular Heartbeat OYes ONo Sinus Trouble OYes ONo Blood Disease OYes ONo Frequent Cough OYes ONo Kidney Problems OYes ONo Spina Bifida OYes ONo Blood Transfusion OYes ONo Frequent Diarrhea OYes ONo Leukemia OYes ONo Stomach/Intestinal Disease ○Yes ○No Breathing Problems OYes ONo Frequent Headaches OYes ONo Liver Disease OYes ONo Stroke ○Yes ○No Bruise Easily OYes ONo Genital Herpes OYes ONo Low Blood Pressure OYes ONo Swelling of Limbs OYes ONo Cancer OYes ONo Glaucoma OYes ONo Lung Disease O Yes O No Thyroid Disease OYes ONo Chemotherapy OYes ONo Hay Fever OYes ONo Mitral Valve Prolapse OYes ONo Tonsillitis OYes ONo Chest Pains OYes ONo Heart Attack/Failure OYes ONo Osteoporosis OYes ONo Tuberculosis OYes ONo Cold Sores/Fever Blisters OYes ONo Heart Murmur O Yes O No Pain in Jaw Joints OYes ONo Tumors or Growths OYes ONo Congenital Heart Disorder OYes ONo Heart Pacemaker OYes ONo Parathyroid Disease OYes ONo OYes ONo Convulsions OYes ONo Heart Trouble/Disease OYes ONo Psychiatric Care OYes ONo Venereal Disease OYes ONo Yellow Jaundice OYes ONo Have you ever had any serious illness not listed above? OYes ONo If ves 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: