Time 8:29 AM | Thomas Unruh D.D.S., | Date 12/20/2017

Eaglesoft Medical History(Copy)(Copy)

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

Are you under a physician's care now?	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
Are you taking any medications, pills, or drugs?	Yes No	If yes
Are you taking Tagamet (Cimetidine)?	Yes No	
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
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
What is your height?		
What is your weight?		
How did you hear about our office?		omment

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
☐ Sunscreen/PABA

Do you use controlled substances? Yes No 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
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Angina Yes No
Emphysema Yes No	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 Yes No
Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No	Asthma Yes No
Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No	Blood Disease Yes No
Frequent Cough Yes No	Kidney Problems Yes No	Blood Transfusion Yes No	Leukemia Yes No
Stomach/Intestinal Disease Yes No	Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No
Stroke Yes No	Bruise Easily Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Mitral Valve Prolapse Yes No	Tonsillitis 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 Yes No	Ulcers Yes No	Heart Trouble/Disease Yes No
Psychiatric Care Yes No	Yellow Jaundice Yes No		

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

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:_____