Velk Family Dentistry **Eaglesoft Medical History**

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