Time 12:38 PM

Icard _Strein Family Dentistry

Date 4/9/2018

Eaglesoft Medical History(Most Recent)

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 yc may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for

Question	Yes	No	If yes
Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a	Yes	No	If yes
Have you ever had a serious head or neck	Yes	No	If yes
Are you taking any medications, pills, or	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or	Yes	No	If yes
Have you ever taken Fosamax, Boniva,	Yes	No	If yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	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
- [ ] Metal
- [ ] Latex
- [ ] Sulfa Drugs
- [ ] Local Anesthetics

Question	Yes	No	If yes
Do you use controlled substances?	Yes	No	If yes
Other?	[ ]		If yes

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

Condition	Yes	No
AIDS/HIV Positive	Yes	No
Alzheimer's Disease	Yes	No
Anaphylaxis	Yes	No
Anemia	Yes	No
Angina	Yes	No
Arthritis/Gout	Yes	No
Artificial Heart Valve	Yes	No
Artificial Joint	Yes	No
Asthma	Yes	No
Blood Disease	Yes	No
Leukemia	Yes	No
Liver Disease	Yes	No
Swelling of Limbs	Yes	No
Thyroid Disease	Yes	No
Chest Pains	Yes	No
Cold Sores/Fever Blisters	Yes	No
Congenital Heart Disorder	Yes	No
Convulsions	Yes	No
Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No
Diabetes	Yes	No
Drug Addiction	Yes	No
Easily Winded	Yes	No
Emphysema	Yes	No
Epilepsy or Seizures	Yes	No
Excessive Bleeding	Yes	No
Excessive Thirst	Yes	No
Fainting Spells/Dizziness	Yes	No
Kidney Problems	Yes	No
Stomach/Intestinal Disease	Yes	No
Stroke	Yes	No
Cancer	Yes	No
Chemotherapy	Yes	No
Heart Attack/Failure	Yes	No
Heart Murmur	Yes	No
Heart Pacemaker	Yes	No
Heart Trouble/Disease	Yes	No
Blood thinner	Yes	No
Hemophilia	Yes	No
Hepatitis A	Yes	No
Hepatitis B or C	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Hives or Rash	Yes	No
Hypoglycemia	Yes	No
Irregular Heartbeat	Yes	No
Spina Bifida	Yes	No
Breathing Problems	Yes	No
Bruise Easily	Yes	No
Glaucoma	Yes	No
Hay Fever	Yes	No
Osteoporosis	Yes	No
Pain in Jaw Joints	Yes	No
Parathyroid Disease	Yes	No
Psychiatric Care	Yes	No
Pre-Med	Yes	No
Radiation Treatments	Yes	No
Recent Weight Loss	Yes	No
Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No
Rheumatism	Yes	No
Scarlet Fever	Yes	No
Shingles	Yes	No
Sickle Cell Disease	Yes	No
Sinus Trouble	Yes	No
Blood Transfusion	Yes	No
Frequent Headaches	Yes	No
Low Blood Pressure	Yes	No
Lung Disease	Yes	No
Mitral Valve Prolapse	Yes	No
Tuberculosis	Yes	No
Tumors or Growths	Yes	No
Ulcers	Yes	No
Venereal Disease	Yes	No

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

Signature of Patient, Parent or Guardian:

X

Date:____________