Goolsby Family Dentistry **Eaglesoft Medical History**

Birth Date: Patient Name: 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 yes Have you ever been hospitalized or had a major operation? O Yes O 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? O Yes O No If yes Do you take, or have you taken, Phen-Fen or Redux? If yes Yes No Have you ever taken Fosamax, Boniva, Actonel or any other Yes No If yes medications containing bisphosphonates? Are you on a special diet? Yes No Do you use tobacco? Yes No Do you use controlled substances? Yes No 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 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 Cortisone Mediane Yes No Hemophilia Yes No Radiation Treatments Yes No Yes No Alzheimer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent WeightLoss Yes No Drug Addiction Hepatitis B or C Renal Dialysis Anaphylaxis Yes No Yes No Yes No Yes No Anemia Yes No Easily Winded Yes No Herpes Yes No Rheumatic Fever Yes No High Blood Pressure Angina Yes No Emphysema Yes No Yes No Rheumatism Yes No Arthritis/Gout Yes No Epilepsy or Seizures Yes No High Cholesterol Yes No Scarlet Fever Yes No Hives or Rash Shingles Artificial Heart Valve Yes No Excessive Bleeding Yes No Yes No Yes No Sickle Cell Disease Artificial Joint Yes No Excessive Thirst Yes No Hypoglycemia Yes No Yes No Fainting Spells/Dizziness Sinus Trouble Asthma Yes No Yes No Irregular Heartbeat Yes No Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Spina Bifida Yes No Frequent Diarrhea Stomach/Intestinal Disease Blood Transfusion Yes No Yes No Leukemia Yes No Yes No Breathing Problems Liver Disease Yes No Yes No Frequent Headaches Yes No Stroke Yes No Low Blood Pressure Swelling of Limbs Bruise Easily Yes No Genital Herpes Yes No Yes No Yes No Thyroid Disease Cancer Yes No Glaucoma Yes No Lung Disease Yes No Yes No Mitral Valve Prolapse Tonsillitis Chemotherapy Yes No Hay Fever Yes No Yes No Yes No Heart Attack/Failure Chest Pains Yes No 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 Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes No Yellow Jaundice O Yes O No Have you ever had any serious illness not listed above? If yes Yes No 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: