Milford Dental Clinic, PC 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 Are you under a physician's care now? Yes No If yes Have you ever been hospitalized or had a major Yes No If ves operation? 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 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 yes any other medications containing bisphosphonates? Are you on a special diet? Yes No Do you use tobacco? Yes No Women: Are you... Nursing? Taking oral contraceptives? Pregnant/Trying to get pregnant? Are you allergic to any of the following? Penicillin Codeine Aspirin Acrylic Latex Sulfa Drugs Local Anesthetics Metal Other? If yes Do you use controlled substances? Yes No If yes Do you have, or have you had, any of the following? Yes No Cortisone Medicine Yes No Hemophilia Yes No Radiation Treatments Yes No AIDS/HIV Positive Yes No Yes No Yes No Yes No Alzheimer's Disease Diabetes Hepatitis A Recent Weight Loss Yes No Yes No Yes No Yes No Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis Yes
No Yes
No Yes No Yes
No Anemia Easily Winded Herpes Rheumatic Fever Yes No Yes No Yes No High Blood Pressure Rheumatism Yes No Angina Emphysema O Yes O No Yes No Arthritis/Gout Yes No Epilepsy or Seizures High Cholesterol Scarlet Fever Yes No Yes No Yes No Yes No Yes No Artificial Heart Valve Excessive Bleeding Hives or Rash Shingles Yes No Artificial Joint Yes No Hypoglycemia Yes No Sickle Cell Disease Yes No Excessive Thirst Yes No Yes No Yes No Asthma Irregular Heartbeat Sinus Trouble Yes
No Yes
No Blood Disease Yes No Frequent Cough Kidney Problems Spina Bifida Yes No Yes No Stomach/Intestinal Disease Yes No **Blood Transfusion** Yes No Frequent Diarrhea Leukemia Yes No Breathing Problems Yes No Frequent Headaches Yes No Liver Disease Yes No Stroke Yes No Bruise Fasily Yes No Genital Herpes 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 Yes
No Yes No Chemotherapy Yes No Hav Fever Mitral Valve Prolapse Tonsillitis Yes No Yes No Yes No Chest Pains Heart Attack/Failure Osteoporosis Yes
No Tuberculosis Yes No Cold Sores/Fever Blisters O Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths 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 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: X Date: