

Northshore Metropolitan
Eaglesoft Medical History (2020)

Patient Name: _____

Birth Date: _____

Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Are you taking any medications for health conditions (e.g. high blood pressure)?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you been told that you snore?	<input type="radio"/> Yes <input type="radio"/> No		
Have you been told you stop breathing while sleeping?	<input type="radio"/> Yes <input type="radio"/> No		
Are you often tired during the day?	<input type="radio"/> Yes <input type="radio"/> No		
Have you ever woken up with shortness of breath or gasping?	<input type="radio"/> Yes <input type="radio"/> No		
Have you ever been diagnosed with Sleep Apnea?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Do you use tobacco or controlled substances or recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Acrylic
<input type="checkbox"/> Metal	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Local Anesthetics

Other? If yes

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.

Review of Systems

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Joint Pain	<input type="radio"/> Yes <input type="radio"/> No
Weight Gain/Loss	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No	Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No
Cannot Sleep	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	Blood in Urine	<input type="radio"/> Yes <input type="radio"/> No	Arthritis	<input type="radio"/> Yes <input type="radio"/> No
Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Frequent Urination	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Urination Urgency	<input type="radio"/> Yes <input type="radio"/> No	Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No
Increased Dryness of Skin	<input type="radio"/> Yes <input type="radio"/> No	Chest Pain or Pressure	<input type="radio"/> Yes <input type="radio"/> No	Iron Deficiency	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No
Mole (Change in Color/Size)	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Bleed Easily	<input type="radio"/> Yes <input type="radio"/> No	Dizziness	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Memory Loss	<input type="radio"/> Yes <input type="radio"/> No
Ear Infections	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack or Stroke	<input type="radio"/> Yes <input type="radio"/> No	Swollen Lymph Nodes	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No
Hearing Loss	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Cancer	<input type="radio"/> Yes <input type="radio"/> No	Flashes/Floaters in Vision	<input type="radio"/> Yes <input type="radio"/> No
Sinus Problems	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Blurred Vision	<input type="radio"/> Yes <input type="radio"/> No
Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No	Heartburn	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain	<input type="radio"/> Yes <input type="radio"/> No
Shortness of Breath	<input type="radio"/> Yes <input type="radio"/> No	Acid Reflux	<input type="radio"/> Yes <input type="radio"/> No	Tumor or Growths	<input type="radio"/> Yes <input type="radio"/> No	Anxiety	<input type="radio"/> Yes <input type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No	Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No
Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Pain in Abdomen	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No
Emphysema/COPD	<input type="radio"/> Yes <input type="radio"/> No	Blood in Stool	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Panic Attacks	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Excessive Hunger	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A or B or C	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? 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: _____

Date: _____