Wenatchee Dental

Eaglesoft Medical History-4.0

Patient Name: ____________________________ Date of Birth: __________ Today's Date: ____________________

Are you under a Doctor's care for a CURRENT illness? Name? ○ **Yes** ○ **No**

- If yes: [ ]

Do you have a regular Primary Care Doctor? Name and Clinic? ○ **Yes** ○ **No**

- If Yes: [ ]

Do you have high blood pressure? ○ **Yes** ○ **No**

- If yes, is it being controlled with medication ____
- How often do you check your blood pressure____

Are you taking any other medications? ○ **Yes** ○ **No**

List of Medications: ____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ **Yes** ○ **No**

- If Yes: [ ]

Does your physician recommend that you take antibiotic premedication before dental treatment?

What antibiotic? ○ **Yes** ○ **No**

- If Yes: [ ]

Have you ever had a major operation, or head and neck injury? ○ **Yes** ○ **No**

- If Yes: [ ]

Are you using any of the following substances?

Tobacco? What type? How often in a week? ____

Illicit drugs which can affect our ability to treat you? ____

We have stairs in our office; would you prefer to avoid the stairs? This will help us assist you better. ○ **Yes** ○ **No**

Women: Are you... ○ Pregnant/ Trying to get pregnant? ○ Nursing? ○ Taking oral contraceptives?

Are you **allergic** or sensitive to any of the following?

○ Aspirin ○ Metal ○ Penicillin ○ Latex ○ Codiene ○ Sulfa Drugs ○ Acrylic

○ Local Anesthetics ○ Other? ____

Do you have any of the following inflammatory diseases **or** Family History of the diseases?

□ Diabetes ( ) Family History □ Heart Disease ( ) Family History □ Stroke ( ) Family History

□ Periodontal Disease ( ) Family History □ Cancer ( ) Family History

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV Positive	○ Yes	○ No	Cortisone Medicine	○ Yes	○ No	Hemophilia	○ Yes	○ No
Alzheimer's disease	○ Yes	○ No	Diabetes	○ Yes	○ No	Hepatitis A	○ Yes	○ No
Recent Weight Loss	○ Yes	○ No	Anaphylaxis	○ Yes	○ No	Drug Addiction	○ Yes	○ No
Hepatitis B or C	○ Yes	○ No	Renal Dialysis	○ Yes	○ No	Easily Winded	○ Yes	○ No
Herpes	○ Yes	○ No	Rheumatic Fever	○ Yes	○ No	Emphysema	○ Yes	○ No
High Blood Pressure	○ Yes	○ No	Rheumatism	○ Yes	○ No	Arthritis / Gout	○ Yes	○ No
Epilepsy or Seizures	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Artificial Heart Valve	○ Yes	○ No
Excessive Bleeding	○ Yes	○ No	Artificial Joint	○ Yes	○ No	Hypoglycemia	○ Yes	○ No
Asthma	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No
Sinus Trouble	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Stomach/Intestinal Disease	○ Yes	○ No
Frequent Headaches	○ Yes	○ No	Liver Disease	○ Yes	○ No	Stroke	○ Yes	○ No
Bruise Easily	○ Yes	○ No	Cancer	○ Yes	○ No	Glaucoma	○ Yes	○ No
Lung Disease	○ Yes	○ No	Thyroid Disease	○ Yes	○ No	Chemotherapy	○ Yes	○ No
Mitral Heart Valve	○ Yes	○ No	Tonsillitis	○ Yes	○ No	Chest Pains	○ Yes	○ No
Heart Attack/Failure	○ Yes	○ No	Osteoporosis	○ Yes	○ No	Cold Sores/Fever Blisters	○ Yes	○ No
Heart Murmur	○ Yes	○ No	Pain in Jaw Joints	○ Yes	○ No	Congenital Heart Disorder	○ Yes	○ No
Heart Pacemaker	○ Yes	○ No	Ulcers	○ Yes	○ No	Heart Trouble /Disease	○ Yes	○ No
Psychiatric Care	○ Yes	○ No	Daytime Sleepiness	○ Yes	○ No	Snoring	○ Yes	○ No

Have you ever had any serious illness not listed above? ____

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:** ___________________________