Medical History

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Austin Meyer D.D.S. Inc.

Eaglesoft Medical History

Time

12:02 PM

DATE *

09/06/2023

Patient's First Name *

Patient's Last Name *

Birth Date *

MM/dd/yyyy

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

Have you ever been hospitalized or had a major operation?

○ Yes ○ No

Have you ever had a serious head or neck injury?

○ Yes ○ No

Are you taking any medications, pills, or drugs?

○ Yes ○ No

When was your last dental visit?

MM/dd/yyyy

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

○ Yes ○ No

Do you use tobacco?

○ Yes ○ No

Do you use controlled substances?

○ 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 ☐ Other?

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

AIDS/HIV Positive

○ Yes ○ No

Radiation Treatments

○ Yes ○ No

Alzheimer's Disease

○ Yes ○ No

Diabetes

○ Yes ○ No

Anaphylaxis
○ Yes ○ No

Drug Addiction
○ Yes ○ No

Hepatitis A, B or C
○ Yes ○ No

Anemia
○ Yes ○ No

High Blood Pressure
○ Yes ○ No

Arthritis/Gout
○ Yes ○ No

Epilepsy or Seizures
○ Yes ○ No

High Cholesterol
○ Yes ○ No

Artificial Heart Valve
○ Yes ○ No

Excessive Bleeding
○ Yes ○ No

Hives or Rash
○ 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

Blood Disease
○ Yes ○ No

Kidney Problems
○ Yes ○ No

Leukemia
○ Yes ○ No

Stomach/Intestinal Disease
○ Yes ○ No

Breathing Problems
○ Yes ○ No

Frequent Headaches
○ Yes ○ No

Liver Disease
○ Yes ○ No

Stroke
○ Yes ○ No

Low Blood Pressure
○ Yes ○ No

Cancer
○ Yes ○ No

Glaucoma
○ Yes ○ No

Lung Disease
○ Yes ○ No

Thyroid Disease
○ Yes ○ No

Chemotherapy
○ Yes ○ No

Allergies (seasonal)
○ Yes ○ No

Mitral Valve Prolapse
○ Yes ○ No

Tonsillitis
○ Yes ○ No

Chest Pains
○ Yes ○ No

Heart Attack/Failure
○ 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

Heart Trouble/Disease
○ Yes ○ No

Anxiety/Derpression
○ Yes ○ No

Sleep Apnea
○ Yes ○ No

ADD/ADHD
○ Yes ○ No

Bacterial Endocarditis
○ Yes ○ No

Blood Thinner
○ Yes ○ No

Have you ever had any serious illness not listed above?
○ 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 *

Date *
09/06/2023