Time 11:36 AM

Tyler Family Dental

Date 8/6/2018

Eaglesoft Medical History - TFD

Patient Name: Birth Date: Date Created:

Are you under a physician's care now? ○Yes ○No If yes

Have you ever been hospitalized or had a major operation? ○Yes ○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? ○Yes ○No If yes

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

Do you use tobacco? ○Yes ○No

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

Condition		Condition		Condition		Condition	
AIDS/HIV Positive	○Yes ○No	Cortisone Medicine	○Yes ○No	Radiation Treatments	○Yes ○No	Alzheimer's Disease	○Yes ○No
Diabetes	○Yes ○No	Hepatitis	○Yes ○No	Anaphylaxis	○Yes ○No	Renal Dialysis	○Yes ○No
Anemia	○Yes ○No	Rheumatic Fever	○Yes ○No	Emphysema	○Yes ○No	Depression	○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	Sickle Cell Disease	○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
Liver Disease	○Yes ○No	Stroke	○Yes ○No	High/Low Blood Pressure	○Yes ○No	Swelling of Limbs	○Yes ○No
Cancer	○Yes ○No	Glaucoma	○Yes ○No	Lung Disease	○Yes ○No	Thyroid Disease	○Yes ○No
Chemotherapy	○Yes ○No	Mitral Valve Prolapse	○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	Heart Trouble/Disease	○Yes ○No
Anxiety	○Yes ○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:

X

Date:_________