Northview Dental P.C.

Date 6/1/2017

Eaglesoft Medical History(Copy)(Copy)(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Disclaimer

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

General Single Questions

Are you currently being treated by a physician for a specific heath concern?	○ Yes ○ No	If yes
Have you been diagnosed with sleep apnea? Do you use a CPAP or other treatment?	○ Yes ○ No	If yes
Have you ever been told you snore?	○ Yes ○ No	If yes
Do you wake up tired or fatigue easily?	○ Yes ○ No	If yes
Do you often wake up with a headache?	○ Yes ○ No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you having any tooth or jaw pain?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	

General List Questions

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 allergies?	○ Yes ○ No	If yes
Do you use controlled substances?	☐	If yes
Height		
Weight		

Current Health

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

☐ AIDS/HIV Positive	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Diabetes	☐ Hepatitis A	☐ Recent Weight Loss
☐ Drug Addiction	☐ Hepatitis B or C	☐ Renal Dialysis	☐ Anemia
☐ Easily Winded	☐ Herpes	☐ Rheumatic Fever	☐ Angina
☐ Emphysema	☐ High Blood Pressure	☐ Rheumatism	☐ Arthritis/Gout
☐ Epilepsy or Seizures	☐ High Cholesterol	☐ Scarlet Fever	☐ Artificial Heart Valve
☐ Excessive Bleeding	☐ Hives or Rash	☐ Artificial Joint	☐ Excessive Thirst
☐ Hypoglycemia	☐ Sickle Cell Disease	☐ Asthma	☐ Fainting Spells/Dizziness
☐ Irregular Heartbeat	☐ Sinus Trouble	☐ Blood Disease	☐ Frequent Cough
☐ Kidney Problems	☐ Blood Transfusion	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Breathing Problems	☐ Frequent Headaches	☐ Liver Disease	☐ Stroke
☐ Bruise Easily	☐ Genital Herpes	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Cancer	☐ Glaucoma	☐ Lung Disease	☐ Thyroid Disease
☐ Chemotherapy	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Chest Pains	☐ Heart Attack/Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Murmur	☐ Pain in Jaw Joints	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Ulcers
☐ Convulsions	☐ Heart Trouble/Disease	☐ Psychiatric Care	☐ Venereal Disease
☐ Dry Mouth	☐ GERD/Acid reflux		

Have you ever had any serious illness not listed	○ 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:_____