River Falls Family Dentistry

Eaglesoft Medical History Rev. 2/15 Birth Date: D

Patient Name:

Date Created:

Diabetes	Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you taking any other prescription medications? Are you taken, or have you taken, Phen-Fen or Redux? Ob you use tobacco? Please specify which type. Yes \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Although dental person	nel primarily treat	t the area in an	d around y	your mouth	, your i	mouth is a part of your er	ntire body. Healt	th problems that you may l	nave, or medic
Operation? Have you ever had a serious head or neck injury?	Operation? Have you ever had a serious head or neck injury?	Are you under a physic	ian's care now?		○ Yes	○No	If yes				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you taking any other prescription medications?	Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you taking any other prescription medications? Yes \ No \ If yes \ Ary additional medications? Yes \ No \ If yes \ Do you take, or have you taken, Phen-Fen or Rediux? Yes \ No \ If yes \ Do you use tobacco? Please specify which type. Yes \ No \ If yes \ Do you have any medical or drug allergies? Please Ist. Yes \ No \ If yes \ Do you have any medical or drug allergies? Please Yes \ No \ If yes \ Do you have any medical or drug allergies? Please Yes \ No \ If yes \ Do you have any medical or drug allergies? Please Yes \ No \ If yes \ Do you have any medical or drug allergies? Please Yes \ No \ If yes \ Do you have any medical or drug allergies? Please Yes \ No \ Hempohilia \ Yes \ No \ Anaphylaxis \ Yes \ No \ Anaphylaxis \ Yes \ No \ Dialysis \ Yes \ No \ Dialysis \ Yes \ No \ Artificial Joint \ Yes \ No \ Hepat this trouble Yes \ No \ Breathing Problems \ Yes \ No \ Glaucoma \ Yes \ No \ Glaucoma \ Yes \ No \ Chest Pains \ Yes \ No \ Cold Sores/Fever Blates \ Yes \ No \ Heart Attack/Failure \ Yes \ No \ Cold Sores/Fever Blates \ Yes \ No \ Heart Attack/Failure \ Yes \ No \ Cold Sores/Fever Blates \ Yes \ No \ Heart Pacemaker \ Yes \ No \ Eating Disorder \ Yes \ No \ Vertigo \ Yes \ No \ If yes \ No \ If yes \ No \ If yes \ No \ Arthritis \ Yes \ No \ Cheet Pains \ Yes \ No \ Heart Pacemaker \ Yes \ No \ Heart Pacemaker \ Yes \ No \ No \ Arthritis \ Yes \ No \ Cheet Pains \ Yes \ No \ Heart Pacemaker \ Yes \ No \ Heart Pacemaker \ Yes \ No \ Arthritis \ Yes \ No \ Cheet Pains \ Yes \ No \ Heart Pacemaker \ Yes \ No \ Cold Sores/Fever Blates \ Yes \ No \ Heart Pacemaker \ Yes \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker \ Yes \ No \ No \ Heart Pacemaker					○No	If yes				
any other medications containing bisphosphonates? Are you taking any other prescription medications? Yes No If yes Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Do you use tobacco? Please specify which type. Yes No If yes Nomen: Are you Pregnant/Trying to get pregnant? Nursing? Nursing? On birth control? Nursing? On birth control? Alzheimer's Disease Yes No If yes Ist. Yes No Hempahilia Yes No Anaphylaxis Yes No Artificial Heart Valve Yes No Asthma Yes No Frequent Headaches Yes No Breathing Problems Yes No Cancer	any other medications containing bisphosphonates? Are you taking any other prescription medications?				○ Yes	○No	If yes				
Are you taking any other prescription medications?	Are you taking any other prescription medications?	Have you ever taken Fo	samax, Boniva,	Actonel or	○ Yes	ONo	If ves				
Any additional medications? Yes No If yes Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Do you use tobacco? Please specify which type. Yes No If yes On byou use tobacco? Please specify which type. Yes No If yes On birth control?	Any additional medications? Or you take, or have you taken, Phen-Fen or Redux? Or you use tobacco? Please specify which type. Or you use tobacco? Please specify which type. Or you use tobacco? Please specify which type. Or you have any medical or drug allergies? Please Or you have any medical or drug allergies? Please Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or you have, or have you had, any of the following? AIDS/HIV Positive Or have you had, any of the following? AIDS/HIV Positive Or have you have, or have you had, any of the following? AIDS/HIV Positive Or have you hade any serious fileses specify with for the following? AIDS/HIV Positive Or have you have or have you had, any of the following	any other medications	containing bisph	osphonates?							
Do you take, or have you taken, Phen-Fen or Redux? \ Yes \ No	Do you take, or have you taken, Phen-Fen or Redux? \ Yes \ No	Are you taking any othe	er prescription n	nedications?	○ Yes	○No	If yes				
Do you use tobacco? Please specify which type.	Do you use tobacco? Please specify which type.					○No	If yes				7%心是 是 验证了。
Or you use tobacco? Please specify which type.	Or you use tobacco? Please specify which type.					∩No	If ves				
Domen: Are you Pregnant/Trying to get pregnant?	ormen: Are you □ Pregnant/Trying to get pregnant? □ Nursing? □ On birth control? □ Alzheimer's Disease										
Pregnant/Trying to get pregnant?	Pregnant/Trying to get pregnant?	you use tobacco? Fi	ease specify wit	ich type.	O res	○N0	It yes				
Do you have any medical or drug allergies? Please Yes No If yes	Do you have any medical or drug allergies? Please										
AIDS/HIV Positive Yes No Diabetes Yes No Hepatitis Yes No Anaphylaxis Yes No Anaphylaxis Yes No High Cholesterol Yes No Artificial Joint Yes No Breathing Problems Yes No Cancer Yes No	AIDS/HIV Positive Yes No Hemophilia Yes No Diabetes Yes No Hepatitis Yes No Anaphylaxis Yes No Dialysis Yes No Anaphylaxis Yes No High Cholesterol Yes No Artificial Heart Valve Yes No Artificial Joint Yes No Glaucoma Yes No Glaucoma Yes No Cancer Yes No Congenital Heart Disorder Yes No Congenital Heart Disorder Yes No Cating Disorder Yes No Cancer Yes No Cating Disorder Yes No Cancer Yes No	☐ Pregnant/Trying to g	get pregnant?		Nursir	ng?			On birth	control?	
AIDS/HIV Positive	AIDS/HIV Positive		al or drug allerg	ies? Please	○ Yes	○No	If yes				
Diabetes	Diabetes	you have, or have you	had, any of the	following?							
Anemia	Anemia	AIDS/HIV Positive	○ Yes ○ No	Hemophilia		O Yes (ONC	Radiation Treatments	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No
Epilepsy or Seizures	Epilepsy or Seizures	Diabetes	○ Yes ○ No	Hepatitis		O Yes (ONC	Anaphylaxis	○ Yes ○ No	Dialysis	○ Yes ○ N
Artificial Joint	Artificial Joint	Anemia		Herpes		O Yes (ONC	Rheumatic Fever	○ Yes ○ No	High Blood Pressure	○ Yes ○ N
Sinus Trouble	Sinus Trouble	Epilepsy or Seizures	○ Yes ○ No	High Cholest	erol	O Yes (ONC	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ N
Breathing Problems	Breathing Problems	Artificial Joint	○ Yes ○ No	Hypoglycemi	а	O Yes (ONC	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ N
Cancer	Cancer	irregular Heartbeat	○ Yes ○ No	Sinus Troubl	е	O Yes (ONC	Kidney Problems	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ N
Chest Pains	Chest Pains	Breathing Problems	○ Yes ○ No	Frequent Hea	adaches	O Yes (ONC	Stroke	○ Yes ○ No	Low Blood Pressure	○ Yes ○ N
Cold Sores/Fever Blisters O Yes O No Congenital Heart Disorder O Yes O No Vertigo O Yes O No Congenital Heart Disorder O Yes O No Vertigo O Yes O No Congenital Heart Disorder O Yes O No Vertigo O Yes O No Congenital Heart Disorder O Yes O No Congenital Heart Disorder O Yes O No Vertigo O Yes O No Congenital Heart Disorder O Yes O No O No Congenital Heart Disorder O Yes O No O No Congenital Heart Disorder O Yes O No O No Congenital Heart Disorder O Yes O No O N	Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Fongenital Heart Disorder Yes No Vertigo Yes No Fongenital Heart Disorder Yes No Vertigo Yes No Fongenital Heart Pacemaker Yes No Fongenital Heart Disorder Ye	Cancer	○ Yes ○ No	Glaucoma		O Yes (ONC	Thyroid Disease	○ Yes ○ No	Chemotherapy	○ Yes ○ N
Congenital Heart Disorder Yes No Heart Pacemaker Yes No Arthritis Yes No Chemical Dependency Yes Cating Disorder Yes No Vertigo Yes No If yes ave you ever had any serious illness not listed Yes No If yes	Congenital Heart Disorder Yes No Heart Pacemaker Yes No Arthritis Yes No Chemical Dependency Yes O Rosetting Disorder Yes No Vertigo Yes No If yes No If yes	Chest Pains	○ Yes ○ No	Heart Attack	Failure	O Yes ()No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ N
Fating Disorder	Fating Disorder	Cold Sores/Fever Blisters	Yes O No	Heart Murmu	ır	O Yes ()No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ N
lave you ever had any serious illness not listed	lave you ever had any serious illness not listed	Congenital Heart Disorder	○ Yes ○ No	Heart Pacem	aker	O Yes (ONC	Arthritis	○ Yes ○ No	Chemical Dependency	○ Yes ○ N
		Eating Disorder	○ Yes ○ No	Vertigo		O Yes (ONC				
	mments:	ave you ever had any	serious illness n	ot listed	○ Yes (ONC	If ves				
miletis:		mments:									
Commencs:		comments:									
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to n tient's) health. It is my responsibility to inform the dental office of any changes in medical status.		gnature of Patient, Parent o	or Guardian:								
the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to nient's) health. It is my responsibility to inform the dental office of any changes in medical status.	nature of Patient, Parent or Guardian:										
ient's) health. It is my responsibility to inform the dental office of any changes in medical status.	nature of Patient, Parent or Guardian:								D	ate:	