Eaglesoft Medical History 3-9-2019(Copy)

Patient Name: (2656) Test Patient

Birth Date: <u>1/1/2001</u>

Date Created: 8/7/2019

Avery our even then hospitalized on had a major operation? Very on that any MEDICATIONS or PIRMOSE Very on the property of the Pirmose of PIRMOSE Very on the property of PIRMOSE medications? Very on the property of PIRMOSE medications? Very on the property of PIRMOSE medications? Very on the PIRMOSE medications such the property of PIRMOSE medications such the PIRMOSE medication such the PIRMOSE medications such the PIRMOSE medication such that the PIRMOSE med								t of your entire body. Health progressing the following ques		that you	may have, or medication that	you may b)e
the you taking any MEDICATIONS or DRUGS? Ves Olio 1	Other than normal checkup care for anything?	s, are you	u under a	physician's	○Yes	○No	If yes [
Do you lake airy 8LOOD THINNER medications? Yes Olso If yes Do you lake airy 8LOOD THINNER medications? Yes Olso If yes If yes Do you lake airy 8LOOD PRESSARE? Yes Olso If yes Do you lake airy 8LOOD PRESSARE? Yes Olso If yes Do you lake airy 8LOOD PRESSARE? Yes Olso If yes Do you lake airy 8LOOD PRESSARE? Yes Olso If yes Life If	Have you ever been hospit	or operation?	○ Yes	○No	If yes [
Do you have HIGH BLOOD PRESSURET Ves Oho If yes Ves Oho V	Are you taking any MEDICA	ATIONS o	or DRUGS	?	○ Yes	○ No	If yes						
Do you use controlled substances? Yes No If yes	Do you take any BLOOD T	ns?	○ Yes										
No count of the part of Fig. No will be a mine of the part of Fig. No will be a mine of the part	o you have HIGH BLOOD		○ Yes										
and how much do you smake per day for you were state \$350-950-No. 12 Program Significant Such for South and \$150-950-No. 12 Program Significant Such yes O No. 15 yes Yes	Do you use controlled subs	stances?			○ Yes	○No	If yes						
Are you over taken BISHO GAP (DATE medications such Yes No If yes Seame, Bank, Active for osteoprosist? If yes Seame, Active for osteoprosist for osteoprosist? If yes Seame, Active for osteoprosist? If yes Seame, Active for osteoprosist? If yes Seame, Active for osteoprosist f		yes, how long	○ Yes	○ No	If yes [
Type	lave you ever taken BISPH	HOSPHON	IATE medi		○ Yes	○ No	If yes [
Or you have any ARTRECAL JOINTS Do you need to take Yes Ne If yes	Do you have DIABETES? Ty		○ Yes	○No	If yes [
rey you on a special diet? Yes No If yes	o you have any ARTIFICL	AL JOINT		need to take	○ Yes	○No	If yes [
e you allergic to any of the following? penicillin	Are you on a special diet?		○ Yes	○ No	If yes								
e you allergic to any of the following? penicillin	omen: Are vou												
Aspirin		pregnant?	?		Nursin	g?			Tak	ing oral (contraceptives?		
Metal Latex Sulfa Drugs Local Anesthetics		following?	,										
Use a lifyes with the providing incorrect information can be dangerous to my (or patient's) health. It is representation.							'				_		
you have, or have you had, any of the following? Heart attack/failure	Metal			Latex				Sulfa Drugs			Local Anesthetics		
Anemia Yes No Anemia Yes No Dry mouth Yes No Herpes Yes Yes O Anagina/chest pains Yes No High cholesterol Yes No Anaphylaxis Yes No Gental herpes Yes Stroke Yes No No Sircike Cell disease Yes No Anaphylaxis Yes No Venereal disease Yes Gregular heartbeat Yes No Heatt trouble/disease Yes No Heatt pacemaker Yes No Heatt pacemaker Yes No Heatt pacemaker Yes No Heatt pacemaker Yes No Wellow jaundice Yes No Asthma Yes No Utlcera Yes Charlifical heartvalve Yes No No Wellow jaundice Yes No Hellow jaundice Yes No Wellow jaundice Yes No Wellow jaundice Yes No Grander/Intestinal Disease Yes No Lung disease Yes No Glaucoma Yes Charlef fever Yes No No Remail dialysis Yes No Swelling of limbs Yes No Alzheimer's disease Yes No Congential heart disorder Yes No Cancer Yes No Cancer Yes No No Hemophilla Yes No Leukemia Yes No Excessive thirst Yes No No Hemophilla Yes No Leukemia Yes No Radiation treatment Yes No Alphylips Yes No No Cancer Yes No Radiation Treatment Yes No Alphylips Yes No Pain in jaw joints Yes No Radiation freatment Yes No Alphylips Yes No Pain in jaw joints Yes Chemotherapy Yes No Radiation treatment Yes No Alphylips Norrect Information can be dangerous to my (or patent's) health. It is anonability to inform the dental office of any changes in medical status.	ther?						If yes [
Angina/chest pains Yes No High cholesterol Yes No Hives orrash Yes No Genital herpes Yes Orstroke Yes No Bruise easily Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Anaphylaxis Yes No Yes No Yes No Yes No Yes Yes No Yes Ye	you have, or have you had	d, any of	the followi	ing?									
Stroke Yes No Bruise easily Yes No Anaphylaxis Yes No Anaphylaxis Yes No Cold sores/fever blistans Yes One Heparttrouble/disease Yes No Heparttrouble/disease Yes No Fainting spells or dizzness Yes No Cold sores/fever blistans Yes One Heparttrouble/disease Yes No Asthma Yes No Tuberculosis Yes Yes No Asthma Yes No Tuberculosis Yes No Stomach/Intestinal Disease Yes No Emphysema Yes No Glaucoma Yes One Heart turmur Yes No Renal dialysis Yes No Easily winded Yes No Alzheimer's disease Yes No Heart turmur Yes No Thyroid disease Yes No Excessive thirst Yes No Alzheimer's disease Yes No Psychiatric care Yes No No No No No No No N	Heart attack/failure	○ Yes	○ No	Anemia		○ Yes	○ No	Dry mouth	○ Yes	○ No	Herpes	○ Yes	ON
Heart trouble/disease	Angina/chest pains	○ Yes	○ No	High cholester	ol	○ Yes	○ No	Hives or rash	○ Yes	○ No	Genital herpes	○ Yes	0
Irregular heartbeat Yes No Hepatitis A,B or C Yes No Hepatitis A,B or C Yes No Heart pacemaker Yes No Liver disease Yes No Artificial heart valve Yes No Yellow jaundice Yes No Entiticial heart valve Yes No Stomach/Intestinal Disease Yes No Emphysema Yes No Glaucoma Yes Coarlet fever Yes No Kidney problems Yes No Kidney problems Yes No Easily winded Yes No Easily winded Yes No Drug addiction Yes Congential heart disorder Yes No Thyroid disease Yes No Excessive thirst Yes No Drug addiction Yes Congential heart disorder Yes No Leukemia Yes No Excessive bleeding Yes No Thurors/Growths Yes No Radiation treatment	Stroke	○ Yes	○ No	Bruise easily		○ Yes	○ No	Anaphylaxis	○ Yes	○No	Venereal disease	○ Yes	0
Heart pacemaker Yes No Liver disease Yes No Arthritical heart valve Yes No Yellow jaundice Yes No Lung disease Yes No Lung disease Yes No Cancer Yes No Mitral valve problems Yes No	Heart trouble/disease	○ Yes	○ No	Sickle Cell dise	ase	○ Yes	○ No	Fainting spells or dizziness	○ Yes	○ No	Cold sores/fever blisters	○ Yes	0
Artificial heartvalve	Irregular heartbeat	○ Yes	○ No	Hepatitis A,B o	r C	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Ulcers	○ Yes	0
Rheumatic fever	Heart pacemaker	○ Yes	○No	Liver disease		○ Yes	○No	Asthma	○ Yes	○No	Tuberculosis	○ Yes	0
Scarlet fever	Artificial heart valve	○ Yes	○No	Yellow jaundic	e	○ Yes	○No	Lung disease	○ Yes	○No	Osteoporosis	○ Yes	0
Heart murmur	Rheumatic fever	○ Yes	○No	Stomach/Intes	tinal Diseas	se OYes	○No	Emphysema	○ Yes	○No	Glaucoma	○ Yes	0
Mitral valve prolapse	Scarlet fever	○ Yes	○No	Kidney probler	ns	○Yes	○ No	Swelling of limbs	○ Yes	○No	Alzheimer's disease	○ Yes	0
Congential heart disorder Yes No Cancer Yes No Recent weightloss Yes No Arthritis/gout Yes Chemophilla Yes No Leukemia Yes No Epilepsy/seizures Yes No Rheumatism Yes Cortisone mediane Yes No Sinus trouble Yes Cortisone mediane Yes No Sinus trouble Yes Cortisone Mediane Yes No Radiation treatment Yes No AIDS/HIV positive Yes No Pain in jaw joints Yes Chemotherapy Yes No If yes Indicated above? Yes No If yes Indicated Apove? If yes Indicated Apove It is form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is nonsibility to inform the dental office of any changes in medical status.	Heart murmur	○ Yes	○ No	Renal dialysis		○ Yes	○No	Easily winded	○ Yes	○ No	Psychiatric care	○ Yes	ON
Congential heart disorder Yes No Cancer Yes No Recent weightloss Yes No Arthritis/gout Yes Chemophilia Yes No Leukemia Yes No Epilepsy/seizures Yes No Rheumatism Yes Checesive bleeding Yes No Tumors/Growths Yes No Cortisone medicine Yes No Sinus trouble Yes Chemotherapy Yes No Shingles Yes No Frequent headaches Yes Obligation treatment Yes No AIDS/HIV positive Yes No Pain in jaw joints Yes Chemotherapy Yes No If yes In In Jaw joints Yes Chemotherapy In Jaw you ever had any serious illness not listed above? Yes No If yes Indicated In Jaw you have you ever had any serious illness not listed above? Yes No If yes Indicated In Jaw you have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is nonsibility to inform the dental office of any changes in medical status.	Mitral valve prolapse			Thyroid diseas	e			Excessive thirst			Drug addiction		
Hemophilia	Congential heart disorder			Cancer				Recent weightloss					
Excessive bleeding													
Blood disease Yes No Chemotherapy Yes No Shingles Yes No Frequent headaches Yes Organical Shingles Yes No Pain in jaw joints Yes Organical Status. Shingles Yes No Frequent headaches Yes Organical Shingles Yes No Pain in jaw joints Yes Organical Shingles Yes Organical Shingl					hs								
Blood transfusion		_	_						_	_			_
mments: ne 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 nonsibility to inform the dental office of any changes in medical status. Inature of Patient, Parent or Guardian:			_										
mments: 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 nonsibility to inform the dental office of any changes in medical status. gnature of Patient, Parent or Guardian:	lave you ever had anv seri	ous illnes	s not list	ed above?	OYes	∩ No	If ves				I		
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 nonsibility to inform the dental office of any changes in medical status.					O ICS	O140	,						
gnature of Patient, Parent or Guardian:	omments:												
gnature of Patient, Parent or Guardian:						answered.	I underst	and that providing incorrect in	formation	can be o	dangerous to my (or patient's)	health. It	t is my
Dato				inges in medical s	iatus.								
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