Time 9:38 AM | Creative Dentistry Of Atlanta | Date 12/6/2015

Revised Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

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	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 of these medications, pills, or drugs?

Pre-Medicaton Before Dental Treatment	Yes No	Antacids	Yes No	Dilantin Or Tegretol	Yes No	Barbiturates	Yes No
St. John's Wart Or Kava-Kava	Yes No	Biaxin	Yes No	Tagamet Or Prilosec	Yes No	Cardizem, Calan, Isoptin	Yes No
Serzone (nefazodone)	Yes No	Grapefruit, Juice, Or Product	Yes No	Diflucan Or Sporonox	Yes No		

Are you taking any other medications, pills, or	Yes No	If yes
Are you taking any herbal supplements?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Are you on a special diet?	Yes No	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use tobacco? If yes, do you smoke or chew? How much per day? How many years?	Yes No	If yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	Yes No	If yes
Do you snore or have you been diagnosed with Sleep Apnea?	Yes No	If yes
Have you ever had a Sleep Study/testing performed? If yes, please give referring Physcian's	Yes No	If yes
Do you clench or grind your teeth at night? Do you wake up with a headache or soreness in facial	Yes No	If yes
Have you ever had Botox/Dysport or Facial Filler treatments such as Juviderm or Restylane?	Yes No	If yes
Are you happy with your smile? If something could be changed about your smile, what would it be?	Yes No	If yes

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
☐ Milk/Milk Products

Other?	☐	If yes
Do you use controlled substances?	Yes No	If yes

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

Abnormal Bleeding From A Cut	Yes No	Abnormal Heart Or Previous Bacterial Endocarditis	Yes No	AIDS/HIV Positive	Yes No	Alzheimer's Disease	Yes No
Anaphylaxis	Yes No	Anemia	Yes No	Angina	Yes No	Arthritis	Yes No
Artificial Joint	Yes No	Asthma	Yes No	Blood Disease	Yes No	Blood Transfusion	Yes No
Breathing Problems	Yes No	Bruise Easily	Yes No	Cancer	Yes No	Chemotherapy	Yes No
Chest Pains	Yes No	Cold Sores/Fever Blisters	Yes No	Congenital Heart Disorder	Yes No	Convulsions	Yes No
Cortisone Medicine	Yes No	Diabetes	Yes No	Drug Addiction	Yes No	Easily Winded	Yes No
Emphysema	Yes No	Epilepsy Or Seizure	Yes No	Excessive Bleeding	Yes No	Excessive Thirst	Yes No
Fainting Spells/Dizziness	Yes No	Frequent Cough	Yes No	Frequent Diarrhea	Yes No	Frequent Headaches	Yes No
Genital Herpes	Yes No	Glaucoma	Yes No	Hay Fever	Yes No	Heart Attack/Failure	Yes No
Heart Murmur	Yes No	Heart Pacemaker	Yes No	Heart Stint	Yes No	Heart Valve Or Heart Transplant	Yes No
Heart Trouble/Disease	Yes No	Hemophilia	Yes No	Hepatitis A	Yes No	Hepatitis B Or C	Yes No
Herpes	Yes No	High Blood Pressure	Yes No	High Cholesterol	Yes No	Hives Or Rash	Yes No
Hypoglycemia	Yes No	Irregular Heartbeat	Yes No	Kidney Problems	Yes No	Leukemia	Yes No
Liver Disease	Yes No	Low Blood Pressure	Yes No	Lung Disease	Yes No	Mitral Valve Prolapse	Yes No
Osteoporosis	Yes No	Pain In Jaw Joints	Yes No	Parathyroid Disease	Yes No	Previous Biopsies	Yes No
Psychiatric Care	Yes No	Psychosis	Yes No	Radiation Treatment	Yes No	Recent Weight Loss	Yes No
Recurrent Illnesses	Yes No	Renal Dialysis	Yes No	Rheumatic Fever	Yes No	Shingles	Yes No
Sickle Cell Disease	Yes No	Sinus Trouble	Yes No	Slow Healing Mouth Sores	Yes No	Sore/Enlarged Lymph Nodes	Yes No
Spina Bifida	Yes No	Stomach/Intestinal Disease	Yes No	Stroke	Yes No	Swelling Of Limbs	Yes No
Thyroid Disease	Yes No	Tonsillitis	Yes No	Tuberculosis	Yes No	Tumors Or Growths	Yes No
Ulcers	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No	Other Conditions	Yes No

Have you ever had any serious illness not listed	Yes No	If yes

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:_____