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Lindenwoods Dental

Eaglesoft Medical History

Patient Name:

Birth Date:

Date Created:

Date:____

Are you under a physician's care now? Yes No If yes Harve you ever been hospitalized or had a major operation? Yes No If yes Harve you tever had a serious head or neck injury? Yes No If yes Do you take, or have you taken, Phen-Pen or Redux? Yes No If yes How you ever had a serious head or neck injury? Yes No If yes Do you take, or have you taken, Phen-Pen or Redux? Yes No If yes Wes No If yes Do you use tobacco? Yes No If yes Do you use tobacco? Yes No If yes If yes Wes No If ye													
Have you ever had a serious head or neck injury? Yes No If yes Are you taken, or have you taken, Phen-Fen or Redux? Yes No If yes Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Are you taken, or have you taken, Phen-Fen or Redux? Yes No If yes Are you on a special det? Yes No If yes Do you use tobacco? Yes No If yes Oner: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives? If yes Other? If yes Other? If yes Other? If yes Other? ADS/HIV Positive Yes No Cortsone Medicine Yes No Allineimer's Disease Yes No Do you have, or have you had, any of the following? Allineimer's Disease Yes No Do Yes No Daddeton Aremia Yes No Easily Winded Yes No Hepps Arefficial insert valve Yes No Excessive Bleeding Yes No Excessive Bleeding Yes No Recent Weight Loss Yes No Recent Weight Loss Yes No Hepps Yes No Recent Weight Loss Yes No Hepps Yes No Recent Weight Loss Yes No Hepps Yes No Recent Weight Loss Yes No Hepps Yes No Sardet Fever Yes No Singles Yes No Hepps Yes No Singles Yes No Singles Yes No Singles Yes No Singles Yes No Hepps Yes No No Hepps No Hepps	Are you under a physician's	care now?			Yes () No	If yes						
ver you taking any medications, pills, or drugs? Yes No If yes Yes No If yes Anoyou taken, or have you taken, Phen-Fen or Redux? Yes No If yes We you on a special diet? Yes No Yes No Yes No If yes We you on a special diet? Yes No Yes No If yes We you on a special diet? Yes No Yes No If yes We you allergie to any of the following? Aspoin Pergnant/Trying to get pregnant? We you allergie to any of the following? Aspoin Pergnant-Yes No Diffue? If yes We you allergie to any of the following? Aspoin Diffue? If yes We you have, or have you had, any of the following? Albs/HIV Positive Yes No Cortisone Medicine Yes No Albreimer's Disease Yes No Diffuels Yes No Albreimer's Disease Yes No Angina Yes No Easily Winded Ardryisout Yes No Englepsy or Selbures Yes No Ardridal Janta Yes No Biood Disease Yes No Frequent Doughesmay Yes No Frequent Doughesmay Yes No Biood Disease Yes No Frequent Dearbeim Yes No Glaucoma Yes No Glaucoma Yes No Conderred Yes No Heart Trouble/Disease Yes No Pergulant Control Easily Winded Yes No Scalet Fever Yes No Combined Problems Yes No Stroke Yes No Tumors or Growths Yes No Compenial Heart Davie Postages Yes No Pergulant Couch Yes No Pergulant Couch Yes No Pergulant Couch Yes No Compenial Heart Davie Postages Yes No Pergulant Couch Yes No Pergulant Couch Yes No Pergulant Couch Yes No No Heart Pacenabler Yes No Pergulant Couch Yes No Pergulant Couch Yes No No Heart Pacenabler Yes No Pergulant Couch Yes No No Heart Pacenabler Yes No Pergulant Couch Yes No No Heart Pacenabler Yes No Pergulant Couch Yes No	lave you ever been hospitalized or had a major operation?				Yes () No	If yes						
Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes Have you or special de?? Yes No If yes Do you use tobacco? Yes No If yes Do you use controlled substances? Yes No If yes Oneman Are you Pregnant/Trying to get pregnant? Are you allergic to any of the following? Appromagned Are you Pregnant/Trying to get pregnant? Are you allergic to any of the following? Appromagned Are you Pregnant/Trying to get pregnant? Are you allergic to any of the following? Appromagned Are you had, any of the following? Appromagned Are you had, any of the following? Appromagned Are you had, any of the following? Alphemer's Disease Yes No Dispay of Selarurs Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Approvables Are you allergic to any of the following? Approvables Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you allergic to any of the following? Approvables Are you Pregnant, Trying to get pregnant? Are you Are y	Have you ever had a seriou	is head or r	neck injur	ry?	e Yes) No	If yes						
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet? Yes No Do you use tobscco? Yes No Do you use tobscco? Yes No Do you use controlled substances? Yes No Do you use controlled substances? Yes No Do you allergic to any of the following? Apprim Pengant/Trying to get pregnant? Nursing? Taking oral contraceptives? Totaling	Are you taking any medicat	ions, pills, d	or drugs?		Yes () No	If yes						
Are you on a special det? Ves No Do you use tobacco? Ves No If yes omen: Are you Pregnant/Trying to get pregnant? Nursing? Pendillin Codeine Acrylic	Do you take, or have you t	aken, Phen	-Fen or F	Redux?	Yes () No	If yes						
Do you use tobacco? Yes No If yes One you use controlled substances? Yes No If yes One you allergic to any of the following? Apprin Periodin Codeine Acrylic				or any other	🖱 Yes 🌘) No	If yes						
Do you use controlled substances? Yes No If yes	Are you on a special diet?				Yes () No							
Pregnant/Trying to get pregnant?	Do you use tobacco?				Yes () No							
Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?	Do you use controlled subst	tances?			O Yes) No	If yes						
e you allergic to any of the following? Agrin	omen: Are you												
Aspirin Pericilin Codeine Acrylic Local Anesthetics Other? If yes Other? If yes Other? If yes Other? If yes Other? ACDS/HIV Positive Yes No Anaphylaxis Yes No Diabetes Yes No Hepatitis A Yes No Hepatitis A Yes No Hepatitis A Yes No Hepatitis A Yes No Hepatitis B or C Yes No Herberts Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No Excessive Thirst Yes No Herberts Yes No Hepatitis B or C Yes No High Cholesterol Yes No Arthritis/Jount Yes No Excessive Thirst Yes No Hepatitis B or C Yes No High Cholesterol Yes No High Cholesterol Yes No Scarlet Fever Yes No Arthritis/Jount Yes No Excessive Thirst Yes No High Cholesterol Yes No Sinus Trouble Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Sinus Trouble Yes No Breating Problems Yes No Genital Herpes Yes No Heart Attack/Fallure Yes No Congenital Heart Disorder Yes No Heart Attack/Fallure Yes No Congenital Heart Disorder Yes No Heart Attack/Fallure Yes No Congenital Heart Disorder Yes No Heart Trouble/Disease Yes No Convusions Yes No Convusions Yes No Heart Trouble/Disease	Pregnant/Trying to get	pregnant?			Nursing?				Ta	aking oral	contraceptives?		
Metal	e you allergic to any of the	following?											
Other? If yes Oyou have, or have you had, any of the following? AIDS/HIV Positive	Aspirin			Penicillin				Codeine			Acrylic		
o you have, or have you had, any of the following? AIDS/HIV Positive Yes No Cortisone Medicine Yes No Hepatitis A Yes No Recent Weight Loss Yes Anaphylaxis Yes No Diabetes Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Easily Winded Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Emphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Anaphylaxis Yes No Emphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Yes Anaphylaxis Pres No Emphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Pres No Emphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Pres No Emphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Pres No Emphysema Yes No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Pres No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Pres No Hepatitis B or C Yes No Recent Weight Loss Yes No Anaphylaxis Pres No Recent Weight Loss Yes No Recent Weight Los	Metal			Latex				Sulfa Drugs			Local Anesthetics		
AIDS/HIV Positive	Other?				Total Control		If yes						
AIDS/HIV Positive	you have, or have you ha	d, any of t	the follow	ing?									
Anaphylaxis				1	e	① Yes	○ No	Hemophilia	Yes	○ No	Radiation Treatments	O Yes	() N
Anemia	Alzheimer's Disease	Yes	⊕ No	Diabetes		Yes	No	Hepatitis A	Yes	⊕ No	Recent Weight Loss	Yes	() N
Angina	Anaphylaxis	Yes	○ No	Drug Addiction		Yes	○ No	Hepatitis B or C	Yes	⊚ No	Renal Dialysis	Yes	01
Arthritis/Gout	Anemia	Yes	⊕ No	Easily Winded		Yes	O No	Herpes	Yes	○ No	Rheumatic Fever	Yes	01
Artificial Heart Valve	Angina	○ Yes	○ No	Emphysema		○ Yes	○ No	High Blood Pressure	Yes	⊘ No	Rheumatism	Yes	() N
Artificial Joint	Arthritis/Gout	○ Yes	○ No	Epilepsy or Seizur	es	(Yes	⊚ No	High Cholesterol		⊚ No	Scarlet Fever	Yes	01
Asthma	Artificial Heart Valve	(Yes	○ No	Excessive Bleedin	g	(Yes	○ No	Hives or Rash	Yes	⊚ No	Shingles	⊕ Yes	01
Blood Disease Yes No Frequent Cough Yes No Leukemia Yes No Spina Blfida Yes Stomach/Intestinal Disease Yes Stomach/Intestina	Artificial Joint	Yes	O No	Excessive Thirst		(Yes	⊕ No	Hypoglycemia	○ Yes	⊕ No	Sickle Cell Disease	Yes	O N
Blood Transfusion Yes No Frequent Diarrhea Yes No Leukemia Yes No Stomach/Intestinal Disease Yes Stroke Yes No Stroke Yes Stroke Yes Stroke Yes No Stroke Yes Stroke	Asthma	○ Yes	○ No	Fainting Spells/Dia	ziness	(Yes	○ No	Irregular Heartbeat	Yes	⊘ No	Sinus Trouble	Yes	(N
Breathing Problems	Blood Disease			Frequent Cough		○ Yes	⊚ No	Kidney Problems	Yes	○ No	Spina Bifida	O Yes	() N
Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Swelling of Limbs Yes Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes Yes No Chemotherapy Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tonsillitis Yes Congenital Heart Disorder Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Ulcers Yes Yes No Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes Yes Yes No Venereal Disease Yes Yes No Yes Order Yes No Yes Order Yes No Yes Order Y	Blood Transfusion			Frequent Diarrhe	а	(Yes	⊚ No	Leukemia	Yes	⊘ No	Stomach/Intestinal Disease	Yes	(N
Cancer Yes No Glaucoma Yes No Lung Disease Yes No Thyroid Disease Yes Ordentherapy Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes Ordentherapy No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes Ordentherapy Ordentherapy Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Venereal Disease Yes Ordenthis	Breathing Problems			Frequent Headac	hes			Liver Disease	Yes	○ No	Stroke	Yes	(N
Cancer	-			Genital Herpes				Low Blood Pressure	⊕ Yes	○ No	Swelling of Limbs	Yes	0 N
Chemotherapy				Glaucoma		O Yes	○ No	Lung Disease			Thyroid Disease	(Yes	O N
Chest Pains				Hay Fever							Tonsillitis		
Cold Sores/Fever Blisters	The state of the s				ire	140					Tuberculosis		
Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Venereal Disease Yes Yes											Tumors or Growths		
Convulsions O Yes O No Heart Trouble/Disease O Yes O No Psychiatric Care O Yes O No Venereal Disease O Yes											Ulcers	_	
				Heart Trouble/Dis	ease			Psychiatric Care	@ Yes	○ No	Venereal Disease	① Yes	01
	Congenital Heart Disorder							2			Yellow Jaundice	(Yes	01
	Congenital Heart Disorder							l .					
	Congenital Heart Disorder		not listed	d above?	O Yes	⊙ No	If yes						