Shawnee Dental

Eaglesoft Medical History(Adult) Page 1

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.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Taking oral contraceptives? ☐ Nursing? ☐ Pregnant/Trying to get pregnant?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Other			

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

☐ Taken Fen-Phen	☐ Anemia	☐ AIDS or HIV Positive	☐ Hepatitis B
☐ Rheumatic Fever	☐ Heart Murmur	☐ Angina Pectoris	☐ Hepatitis C
☐ Ulcers	☐ Arthritis	☐ Heart Pacemaker	☐ Hemophilia
☐ Glaucoma	☐ Thyriod Disease	☐ Veneral Disease	☐ Tuberculosis
☐ Sinus Problems	☐ Low Blood Pressure	☐ Asthma	☐ Taken Osteoporosis Medicine
☐ Irregular Heatbeat	☐ Blood Transfusions	☐ Heart Attack	☐ Artificial Heart Valve
☐ Breathing Problems	☐ Emphysema	☐ Tumors or Growths	☐ Artificial Joint/Replacement
☐ High Blood Pressure	☐ Diabetes	☐ Chemotherapy	☐ Stroke
☐ Cold Sores/Fever Blisters	☐ Kidney Problems	☐ Cancer	☐ Excessive Bleeding
☐ Liver Disease	☐ Congenital Heart Defect	☐ Gags Easily	☐ Radiation Treatments to Head
☐ Recent Weight Loss	☐ Cortisone/Steroid Therapy	☐ Psychiatric Problems	☐ Epilepsy or Seizures
☐ Mitral Valve Prolapse	☐ Drug Abuse	☐ Hepatitis A	☐ Frequent Headaches

Medications and other illnesses not listed above:

Change in Privacy Practices, Access to Records(HIPPA):

I would like to add or remove the following person(s) access to these records:

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:_____

DENTAL HISTORY

Primary reason for this dental appointment: ___Examination
___Emergency
___Consultation

Do you have a specific dental Problem? If yes-Describe_____

Time since last dental visit? _____

Are you satisfied with your past dentistry? _____

How often do you brush your teeth? _____ Floss? _____

Do you like the way your teeth look? _____

Have you been treated by a periodontist(gum specialist)? ____

Have you been treated by an orthodontist(braces)? _____

Are you bothered with:

Tender teeth when chewing	Yes___No___
Bleeding gums	Yes___No___
Bad breath	Yes___No___
Clicking or popping of your jaw	Yes___No___
Tired jaws	Yes___No___
Spaces between teeth	Yes___No__
Food catching between teeth	Yes___No___
Sensitivity to hot, cold, sweets	Yes___No___

Name of your previous dentist. _____ City_____

How did you find out about us?:

Friend or Relative ___ Name _____
Phone book ___
Office Sign ___
Family comes here ___
Other _____

Any Other Information: