CCDA Calhoun Clemson DENTAL ASSOCIATES, LLC

# Eaglesoft Medical History 2021

Birth Date:

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.

| | | |
|---|---|---|
| Do you have a Primary Care Physician? Please list name and phone number | ◯ 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 on a special diet? | ◯ Yes ◯ No | If yes |
| Do you use tobacco products or vape? | ◯ Yes ◯ No | |
| Do you drink alcohol? How many drinks/week? | ◯ Yes ◯ No | If yes |
| Have you had any type of Joint Replacement surgery? List dates of surgery | ◯ Yes ◯ No | If yes |
| Have you ever had a heart valve replacement or vascular graft? List dates of surgery | ◯ Yes ◯ No | If yes |
| Have you ever taken any bisphosphonate medications (Fosamax, Boniva, Reclast, Zometa, Evista)? | ◯ Yes ◯ No | If yes |
| Are you currently on any Blood Thinners (Warfarin, Coumadin, Pradaxa, Plavix, Eliquis, Aspirin, Xarelto)? | ◯ Yes ◯ No | If yes |
| Are you taking any medications? List ALL medications | ◯ 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 |

Other Known Allergies ◯ Yes ◯ No If yes

## MEDICAL HISTORY

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

| | | | |
|---|---|---|---|
| ☐ Angina | ☐ Anemia | ☐ Parathyroid Disease | ☐ Kidney Problems |
| ☐ Artificial Heart Valve | ☐ Blood Disease | ☐ Thyroid Disease | ☐ Renal Dialysis |
| ☐ Bacterial Endocarditis | ☐ Blood Transfusion | ☐ Gastrointestinal Disease | ☐ Swelling of Limbs |
| ☐ Congential Heart Disorder | ☐ Bruise Easily | ☐ Ulcers | ☐ Cancer |
| ☐ Heart Attack | ☐ Excessive Bleeding | ☐ Arthritis | ☐ Chemotherapy Treatment |
| ☐ Heart Disease | ☐ Leukemia | ☐ Osteoperosis | ☐ Radiation Treatment |
| ☐ Heart Murmur | ☐ Sickle Cell Disease | ☐ Osteonecrosis | ☐ Anaphylaxis |
| ☐ High Blood Pressure | ☐ Asthma | ☐ Artificial Joint | ☐ Hives |
| ☐ Low Blood Pressure | ☐ Breathing Problems | ☐ Alzheimer's Disease | ☐ Shingles |
| ☐ High Cholesterol | ☐ Emphysema | ☐ Epilepsy | ☐ Scarlet Fever |
| ☐ Irregular Heartbeat | ☐ Tuberculosis | ☐ Parkinson's Disease | ☐ Herpes Simplex Virus |
| ☐ Mitral Valve Prolapse | ☐ Hepatitis A | ☐ Vertigo | ☐ Anxiety |
| ☐ Pacemaker | ☐ Hepatitis B | ☐ Diabetes | ☐ Depression |
| ☐ Stroke | ☐ Hepatitis C | ☐ Excessive Thirst | ☐ Drug Addiction |
| ☐ AIDS/HIV Positive | ☐ Liver Disease | ☐ Hypoglycemia | |

Do you have any medical condition not listed above? ◯ Yes ◯ No If yes

## DENTAL HISTORY

Do you have or have you experienced any of the following:

| | |
|---|---|
| ☐ Dental Anxiety or Phobia | ☐ Bruxism (Teeth Clenching) |
| ☐ Dry Mouth | ☐ Frequent Cold Sores or Fever Blisters |
| ☐ Sleep Apnea | ☐ Frequent Headaches |
| ☐ Popping or Clicking in Jaw Joints | ☐ Chronic Sinus Infections |

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:_____