Signature of Patient, Parent or Guardian:

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Ridge Dental Group, LTD Eaglesoft Medical History

Birth Date:

Date Created:

Date:

Patient Name:

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? OYes ONo If ves Have you ever been hospitalized or had a major operation? OYes ONo If yes Have you ever had a serious head or neck injury? OYes ONo If yes Are you taking any medications, pills, or drugs? OYes ONo If yes Do you take, or have you taken, Phen-Fen or Redux? OYes ONo If yes Have you ever taken Fosamax, Boniva, Actonel or any other OYes ONo If yes medications containing bisphosphonates? Are you on a special diet? OYes ONo Do you use tobacco? OYes ONo Do you use controlled substances? OYes ONo If yes Women: Are vou... Pregnant/Trying to get pregnant? ■ Nursing? Taking oral contraceptives? Are you allergic to any of the following? Aspirin Peniallin Codeine Acrylic Metal Latex Sulfa Drugs Local Anesthetics Other? If yes Do you have, or have you had, any of the following? AIDS/HIV Positive OYes ONo Cortisone Medicine OYes ONo Hemophilia OYes ONo Radiation Treatments OYes ONo Alzheimer's Disease OYes ONo Diabetes OYes ONo Hepatitis A OYes ONo Recent Weight Loss ○Yes ○No Anaphylaxis OYes ONo Drug Addiction OYes ONo Hepatitis B or C ○Yes ○No Renal Dialysis OYes ONo Anemia OYes ONo Easily Winded OYes ONo Herpes OYes ONo Rheumatic Fever OYes ONo Angina OYes ONo Emphysema OYes ONo High Blood Pressure OYes ONo Rheumatism OYes ONo Arthritis/Gout OYes ONo Epilepsy or Seizures OYes ONo High Cholesterol OYes ONo Scarlet Fever OYes ONo Artificial Heart Valve OYes ONo Excessive Bleeding OYes ONo Hives or Rash OYes ONo Shingles OYes ONo Artificial Joint OYes ONo Excessive Thirst OYes ONo Hypoglycemia OYes ONo Sickle Cell Disease OYes ONo Asthma OYes ONo Fainting Spells/Dizziness OYes ONo Irregular Heartbeat OYes ONo Sinus Trouble OYes ONo Blood Disease ○Yes ○No Frequent Cough OYes ONo Kidney Problems OYes ONo Spina Bifida OYes ONo **Blood Transfusion** OYes ONo Frequent Diarrhea OYes ONo Leukemia OYes ONo Stomach/Intestinal Disease OYes ONo Breathing Problems OYes ONo Frequent Headaches ○Yes ○No Liver Disease OYes ONo Stroke OYes ONo Bruise Easily OYes ONo Genital Herpes OYes ONo Low Blood Pressure OYes ONo Swelling of Limbs OYes ONo Cancer OYes ONo Glaucoma OYes ONo Lung Disease OYes ONo Thyroid Disease OYes ONo Chemotherapy OYes ONo Hav Fever OYes ONo Mitral Valve Prolapse OYes ONo Tonsillitis OYes ONo Chest Pains OYes ONo Heart Attack/Failure OYes ONo Osteoporosis ○Yes ○No **Tuberculosis** OYes ONo Cold Sores/Fever Blisters OYes ONo Heart Murmur OYes ONo Pain in Jaw Joints OYes ONo Tumors or Growths OYes ONo Congenital Heart Disorder Heart Pacemaker OYes ONo OYes ONo Parathyroid Disease OYes ONo Ulcers OYes ONo Convulsions OYes ONo Heart Trouble/Disease OYes ONo Psychiatric Care OYes ONo Venereal Disease OYes ONo Yellow Jaundice OYes ONo Have you ever had any serious illness not listed above? OYes ONo If ves Comments: 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.