Elizabeth G. Mitchell, DDS, LLC **Eaglesoft Medical History**

Patient Name: Birth Date: Date Created:

Although dental person	nel primarily treat	the area in and around y	our mouth	, your r	mouth is a part of your en	tire body. Healt	n problems that you may h	nave, or medica
Are you under a physic	Yes (∋ No	If yes					
Have you ever been ho operation?	a major Yes (∋ No	If yes					
Have you ever had a se	erious head or ne	eck injury?	∋ No	If yes				
Are you taking any medications, pills, or drugs?				If yes				
Do you take, or have yo	en or Redux? Yes	no No	If yes					
Have you ever taken Fo								
any other medications) NO	If yes				
Are you on a special di	Yes (∋ No						
Do you use tobacco?	Yes (O Yes No						
Nomen: Are you								
Pregnant/Trying to	get pregnant?	Nursin	g?			Taking or	al contraceptives?	
re you allergic to any of	the following?							
Aspirin		Penicillin			Codeine		Acrylic	
☐ Metal		Latex			Sulfa Drugs		Local Anesthetics	
Other?				If yes				
Do you use controlled s	substances?	O Yes (∋ No	If yes				
,								
you have, or have you		1						0 1/ 0 11
AIDS/HIV Positive	Yes No No	Cortisone Medicine	O Yes		Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	YesNoYesNo	Diabetes	Yes (Yes (Hepatitis A	Yes No Yes No	Recent Weight Loss	
Anaphylaxis	Yes No	Drug Addiction	Yes (Hepatitis B or C	Yes No	Renal Dialysis	O Yes O No
Anemia	Yes No	Easily Winded	O Yes		Herpes	○ Yes ○ No	Rheumatic Fever Rheumatism	O Yes O No
Angina	Yes No	Emphysema	Yes (High Blood Pressure	Yes No	Scarlet Fever	O Yes O No
Arthritis/Gout Artificial Heart Valve	Yes No	Epilepsy or Seizures Excessive Bleeding	O Yes		High Cholesterol Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	O Yes		Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness			Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	⊚ Yes ⊚ No	Frequent Cough	⊚ Yes (Kidney Problems	○ Yes ○ No	Spina Bifida	⊚ Yes ⊚ No
Blood Transfusion	⊚ Yes ⊚ No	Frequent Diarrhea	O Yes		Leukemia	Yes No	Stomach/Intestinal Disease	⊚ Yes ⊚ No
Breathing Problems		Frequent Headaches	⊚ Yes (Liver Disease		Stroke	⊚ Yes ⊚ No
Bruise Easily	Yes No	Genital Herpes	⊚ Yes (Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	⊚ Yes (Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	⊚ Yes (Mitral Valve Prolapse	Yes No	Tonsillitis	⊚ Yes ⊚ No
Chest Pains	Yes No	Heart Attack/Failure	⊚ Yes (Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blister		Heart Murmur	⊚ Yes (Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder		Heart Pacemaker	Yes (⊚ No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	⊚ Yes (⊚ No	Psychiatric Care		Venereal Disease	Yes No
							Yellow Jaundice	Yes No
Have you ever had any	serious illness n	ot listed	∋ No	If yes	1		<u> </u>	
Comments:								
		ns on this form have beer nform the dental office of				providing incorred	t information can be dang	erous to my (o
ignature of Patient, Parent	or Guardian: ———							
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