MARK A. MYERS, DDS Eaglesoft Medical History Birth Date:

Date Created:

Patient Name:

Are you under a physician's care now?		Yes	○ No	If yes				
Have you ever been hospitalized or had a major operation? Have you ever had a serious head or neck injury?		0.5 vs		If yes				
		eck injury? Yes	○ No	If yes				
Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Are you on a special diet?			⊕ No	If yes				*******************************
			2000 1000	2000 10000000				
			⊘ No	If yes				
			○ No	If yes				
			○ No					
Do you use tobacco?			ONO					
/omen: Are you						Lineary		
Pregnant/Trying to get pregnant?			ursing? Taking oral contraceptives?					
re you allergic to any of th	ne following?							
Aspirin		Penicillin			Codeine		Acrylic	
☐ Metal		Latex			Sulfa Drugs		Local Anesthetics	
Other?				If yes				
Do you use controlled su	bstances?	Yes	○ No	If yes				
o you have, or have you h	and any of the	following?						
	au, any or the	Cortisone Medicine	Yes	○ No	Hemophilia		Radiation Treatments	Yes N
	○ Yes ○ No	Diabetes	O Yes		Hepatitis A	O Yes O No	Recent Weight Loss	⊕ Yes ⊕ N
	Yes No	Drug Addiction	Yes		Hepatitis B or C	○ Yes ○ No	Renal Dialysis	O Yes O N
1 1	Yes No	Easily Winded	⊚ Yes		Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ N
	O Yes O No	Emphysema	Yes		High Blood Pressure	Yes No	Rheumatism	○ Yes ○ N
3	Yes No		© Yes		High Cholesterol	Yes No	Scarlet Fever	○ Yes ○ N
	Yes No	Epilepsy or Seizures				Total Control of the	2004309 00	
		Excessive Bleeding	Yes		Hives or Rash	O Yes O No	Shingles	○ Yes ○ N
	Yes No	Excessive Thirst	O Yes		Hypoglycemia	Yes No	Sickle Cell Disease	○ Yes ○ N
	O Yes O No	Fainting Spells/Dizzines			Irregular Heartbeat	Yes No	Sinus Trouble	○ Yes ○ N
	O Yes O No	Frequent Cough	Yes	○ No	Kidney Problems	Yes No	Spina Bifida	O Yes O N
Blood Transfusion	🔘 Yes 🔘 No	Frequent Diarrhea	Yes	○ No	Leukemia	Yes No	Stomach/Intestinal Disease	O Yes O N
Breathing Problems	🔿 Yes 💮 No	Frequent Headaches	Yes	O No	Liver Disease	Yes No	Stroke	O Yes O N
Bruise Easily	🔿 Yes 🗇 No	Genital Herpes	Yes	○ No	Low Blood Pressure	O Yes O No	Swelling of Limbs	
Cancer	Yes No	Glaucoma	Yes	O No	Lung Disease	Yes No	Thyroid Disease	O Yes O N
Chemotherapy	Yes No	Hay Fever	Yes	○ No	Mitral Valve Prolapse	Tes No	Tonsillitis	○ Yes ○ N
ANAPIGMENT CONTROL OF THE PARTY	O Yes O No	Heart Attack/Failure	Yes	⊘ No	Osteoporosis	O Yes O No	Tuberculosis	○ Yes ○ N
Cold Sores/Fever Blisters		Heart Murmur	Yes		Pain in Jaw Joints	O Yes O No	Tumors or Growths	
Congenital Heart Disorder		Heart Pacemaker	Yes		Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ N
	Yes No	Heart Trouble/Diseas			Psychiatric Care	○ Yes ○ No	Venereal Disease	O Yes O N
Convaisions	<u> </u>	ricare rroddie, biseds	C 107		r sychiatric care	0 140 0 110	Yellow Jaundice	○ Yes ○ N
Have you ever had any s	erious illness r	oot listed 🔘 Yes	⊘ No	If yes				
omments:								
Comments:								

Signature of Patient, Parent or Guardian:

Date:_____