

Eaglesoft Medical History

Patient Name: **Jacqueline Jeambey**

Birth Date: **09/14/1993**

Date Created: **9/23/23**

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? 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 taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phен-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? 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? If yes

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

AIDS/HIV Positive <input type="radio"/> Yes <input checked="" type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input checked="" type="radio"/> No	Hemophilia <input type="radio"/> Yes <input checked="" type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input checked="" type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input checked="" type="radio"/> No	Diabetes <input type="radio"/> Yes <input checked="" type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input checked="" type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input checked="" type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input checked="" type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input checked="" type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input checked="" type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input checked="" type="radio"/> No
Anemia <input type="radio"/> Yes <input checked="" type="radio"/> No	Easily Winded <input type="radio"/> Yes <input checked="" type="radio"/> No	Herpes <input type="radio"/> Yes <input checked="" type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input checked="" type="radio"/> No
Angina <input type="radio"/> Yes <input checked="" type="radio"/> No	Emphysema <input type="radio"/> Yes <input checked="" type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input checked="" type="radio"/> No	Rheumatism <input type="radio"/> Yes <input checked="" type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input checked="" type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input checked="" type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input checked="" type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input checked="" type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input checked="" type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input checked="" type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input checked="" type="radio"/> No	Shingles <input type="radio"/> Yes <input checked="" type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input checked="" type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input checked="" type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input checked="" type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input checked="" type="radio"/> No
Asthma <input checked="" type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input checked="" type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input checked="" type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input checked="" type="radio"/> No
Blood Disease <input type="radio"/> Yes <input checked="" type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input checked="" type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input checked="" type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input checked="" type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input checked="" type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input checked="" type="radio"/> No	Leukemia <input type="radio"/> Yes <input checked="" type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input checked="" type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input checked="" type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input checked="" type="radio"/> No	Liver Disease <input type="radio"/> Yes <input checked="" type="radio"/> No	Stroke <input type="radio"/> Yes <input checked="" type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input checked="" type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input checked="" type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input checked="" type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input checked="" type="radio"/> No
Cancer <input type="radio"/> Yes <input checked="" type="radio"/> No	Glaucoma <input type="radio"/> Yes <input checked="" type="radio"/> No	Lung Disease <input type="radio"/> Yes <input checked="" type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input checked="" type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input checked="" type="radio"/> No	Hay Fever <input type="radio"/> Yes <input checked="" type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input checked="" type="radio"/> No	Tonsillitis <input checked="" type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input checked="" type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input checked="" type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input checked="" type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input checked="" type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input checked="" type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input checked="" type="radio"/> No	Pain in Jaw Joints <input checked="" type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input checked="" type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input checked="" type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input checked="" type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input checked="" type="radio"/> No	Ulcers <input type="radio"/> Yes <input checked="" type="radio"/> No
Convulsions <input type="radio"/> Yes <input checked="" type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input checked="" type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input checked="" type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input checked="" type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input checked="" type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes

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.

Signature of Patient, Parent or Guardian: Date: **9/23/23**

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