Edisto Dental Associates, LLC
Eaglesoft Medical History

Patient Name: _____ Birth Date: _____ Date Created: _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is 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 can receive. Thank you for answering the following questions.

Are you under a physician's care now?	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, Phen-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	If Yes:
Do you use tobacco?	Yes	No	If Yes:

Women: Are you…
[ ] Pregnant/Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptive?

Are you allergic to any of the following?

[ ] Aspirin	[ ] Penicillin	[ ] Codeine	[ ] Acrylic
[ ] Metal	[ ] Latex	[ ] Sulfa Drugs	[ ] Local Anesthetics

Other?	[ ] Yes	[ ] No	If Yes:
Do you use controlled substances?	[ ] Yes	[ ] No	If Yes:

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

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

Have you ever had a serious illness not listed? [ ] Yes [ ] No If Yes:

Comments:

_____

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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: _____

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Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. 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.

Payment for all treatment and services rendered are my responsibility and are rendered at time of appointment unless prior agreements have been made with the appropriate Edisto Dental Associate.

_____ _____
PATIENT SIGNATURE DATE

Sign here if patient is a child or requires a guardian:

_____ _____
PARENT/GUARDIAN SIGNATURE DATE