Eaglesoft Medical History(Sleep Apnea)

Patient Name: Birth Date: Date Created:

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, 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
Do you use controlled substances?	Yes No	If yes
Do you snore or have you been told that you snore?	Yes No	If yes
Have you ever used a C-PAP machine?	Yes No	If yes
Have you ever had a sleep study, or told you to get one? If so, when?	Yes No	If yes
Last Dental Visit, When/where?	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	Yes No	Radiation Treatments	Yes No	Alzheimer's Disease	Yes No	Diabetes	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis A, B or C	Yes No	Herpes	Yes No
Emphysema	Yes No	High Blood Pressure	Yes No	Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No
High Cholesterol	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Hypoglycemia	Yes No	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Sinus Trouble	Yes No	Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No
Leukemia	Yes No	Stomach/Intestinal Disease	Yes No	Breathing Problems	Yes No	Frequent Headaches	Yes No
Liver Disease	Yes No	Stroke	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Heart Pacemaker	Yes No
Ulcers	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Insomia	Yes No
Trouble Sleeping	Yes No	Depression	Yes No	Acid Reflux	Yes No	Artificial Heart Valve	Yes No

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:_____