Patient Name:

Aspire Dental Care, PLLC Eaglesoft Medical History

Birth Date:

Date Created:

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? 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			Yes () No	If yes				
			Yes O No	If yes				
			Yes (No	If yes				
			Yes () No	If yes				
medications containing bisp	phosphonates?							
Are you on a special diet? Do you use tobacco? Do you use controlled substances?			Yes (No					
			Yes O No					
			Yes No	If yes				
/omen: Are you Pregnant/Trying to get p	regnant?		Nursing?			☐ Taking ora	contraceptives?	
re you allergic to any of the f	following?	Penicillin			Codeine		Acrylic	
Metal		Latex			Sulfa Drugs		Local Anesthetics	
Bad State State		-						
Other?		[If yes				
you have, or have you had	l, any of the follow	ing?			ų.			
AIDS/HIV Positive	○ Yes ○ No	Cortisone Median	e O Yes	O No	Hemophila	○ Yes ○ No	Radiation Treatments	O Yes O
Alzheimer's Disease	○ Yes ○ No	Diabetes	() Yes	O No	Hepatitis A	O Yes O No	Recent Weight Loss	O Yes O
Anaphylaxis	O Yes O No	Drug Addiction	O Yes	O No	Hepatitis B or C	O Yes O No	Renal Dialysis	O Yes O
Anemia	O Yes O No	Easily Winded	O Yes	O No	Herpes	O Yes O No	Rheumatic Fever	O Yes O
Angina	O Yes O No	Emphysema	() Yes	O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O
Arthritis/Gout	O Yes O No	Epilepsy or Seizur	es () Yes	O No	High Cholesterol	O Yes O No	Scarlet Fever	O Yes O
Artificial Heart Valve	O Yes O No	Excessive Bleedin	O Yes	O No	Hives or Rash	O Yes O No	Shingles	O Yes O
Artificial Joint	○ Yes ○ No	Excessive Thirst		O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O
Asthma	O Yes O No	Fainting Spells/Di		O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O
Blood Disease	O Yes O No	Frequent Cough		() No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O
Blood Transfusion	O Yes O No	Frequent Diarrhea		O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O
Breathing Problems	O Yes O No	Frequent Headach		O No	Liver Disease	O Yes O No	Stroke Swelling of Limbs	O Yes O
Bruise Easily	O Yes O No	Genital Herpes		O No	Low Blood Pressure	O Yes O No	Swelling of Limbs Thyroid Disease	O Yes O
Cancer	O Yes O No	Glaucoma Hay Fever		O No	Lung Disease Mitral Valve Prolapse	O Yes O No	Tonsilitis	O Yes O
Chemotherapy Chest Pains	O Yes O No	Heart Attack/Failu		O No	Osteoporosis	Yes No	Tuberculosis	O Yes O
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur		O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O
Congenital Heart Disorder	O Yes O No	Heart Pacemaker		O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O
Convulsions	O Yes O No	Heart Trouble/Dis		O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O
	0.00			1000	SCENE CONTROL SECTION		Yellow Jaundice	O Yes O
				6.6				
Have you ever had any serio	ous illness not list	ed above?	Yes (No	If yes				

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Have you ever been hospitalized or had a major operation?			Yes () No	If yes				
Name was a section of a section	a hand as not be	2002						
Have you ever had a serious head or neck injury? Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux?			Yes No	If yes				
			Yes (No					
			Yes No	If yes				
Mave you ever taken Fosar medications containing bis		nel or any other	Yes (No	If yes				
Are you on a special diet?		(Yes (No					
Do you use tobacco? Do you use controlled substances?			Yes (No					
			Yes (No	lf yes				
Vomen: Are you								
Pregnant/Trying to get p	pregnant?		Nursing?			Taking or	al contraceptives?	
re you allergic to any of the	following?							
Aspirin		Penicillin			Codeine		Acrylic	
Metal		Latex			Sulfa Drugs		Local Anesthetics	
Other?		0	1	[f yes				
to you have, or have you had	d, any of the foliou	vinn?						
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Anaphylaxis	O Yes O No	Drug Addiction	() Yes	O No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	O Yes O !
Anemia	O Yes O No	Easily Winded	○ Yes	O No	Herpes	Yes No	Rheumatic Fever	O Yes O
Angina	O Yes O No	Emphysema	○ Yes	O No	High Blood Pressure	O Yes O No	Rheumatism	O Yes O
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizure	s Yes	O No	High Cholesterol	Yes No	Scarlet Fever	() Yes () !
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes	O No	Hives or Rash	○ Yes ○ No	Shingles	O Yes O !
Artificial Joint	O Yes O No	Excessive Thirst	O Yes	() No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	O Yes O
Asthma	○ Yes ○ No	Fainting Spells/Dia	ziness () Yes	O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O
Blood Disease	O Yes O No	Frequent Cough	() Yes	O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes Of
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes	O No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	O Yes O1
Breathing Problems	O Yes O No	Frequent Headach	es O Yes	O No	Liver Disease	○ Yes ○ No	Stroke	O Yes O
Bruise Easily	O Yes O No	Genital Herpes	O Yes	○ No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O
Cancer	O Yes O No	Glaucoma	O Yes	O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O !
Chemotherapy	O Yes O No	Hay Fever	O Yes	(No	Mitral Valve Prolapse	○ Yes ○ No	Tonsilles	O Yes O !
Chest Pains	O Yes O No	Heart Attack/Failu	re () Yes	() No	Osteoporosa	Yes No	Tuberculoss	O Yes O
Cold Sores/Fever Blisters	O Yes O No	Heart Murmur	○ Yes	O No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○Yes ○1
Congenital Heart Disorder	O Yes O No	Heart Pacemaker	○ Yet	○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	O Yes O !
Convulsions	O Yes O No	Heart Trouble/Dis	ease 🔘 Yes	() No	Psychiatric Care	○ Yes ○ No	Venereal Disease	O Yes O !
							Yellow Jaundice	O Yes O !
Have you ever had any serio	ous illness not list	ted above?	Yes () No	If yes				

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