Maple Ridge Dental Eaglesoft Medical History Registration

Patient Name: _____ DOB: _____

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.

Health Information

Are you under a physician's care now? Name/Nmber?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation within the past 2 years?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs? List	◯ Yes ◯ No	If yes
Are you allergic to Latex?	◯ Yes ◯ No	
Are you allergic to any drugs?	◯ Yes ◯ No	If yes
Are you allergic to any foods or any metals?	◯ Yes ◯ No	If yes
Do you use tobacco? What and how often?	◯ Yes ◯ No	If yes
Do you use controlled substances? What?	◯ Yes ◯ No	If yes
Do you bleed excessively upon injury?	◯ Yes ◯ No	
Are there any other conditions of which we should be aware?	◯ Yes ◯ No	If yes

Physician/Pharmacy

Do you have a Primary Care Physician? If yes please provide Name/Location/Phone Number	◯ Yes ◯ No	If yes: _____
Pharmacy of Choice? Name/Location	◯ Yes ◯ No	If yes: _____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Health History

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

AIDS/HIV Positive ☐ Yes ☐ No	Hemophilia ☐ Yes ☐ No	Radiation Treatments ☐ Yes ☐ No	Alzheimer's Disease ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Hepatitis A ☐ Yes ☐ No	Anaphylaxis ☐ Yes ☐ No	Drug Addiction ☐ Yes ☐ No
Hepatitis B or C ☐ Yes ☐ No	Renal Dialysis ☐ Yes ☐ No	Anemia ☐ Yes ☐ No	Herpes ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Rheumatism ☐ Yes ☐ No
Epilepsy or Seizures ☐ Yes ☐ No	Artificial Heart Valve ☐ Yes ☐ No	Excessive Bleeding ☐ Yes ☐ No	Hives or Rash ☐ Yes ☐ No
Shingles ☐ Yes ☐ No	Artificial Joint ☐ Yes ☐ No	Hypoglycemia ☐ Yes ☐ No	Sickle Cell Disease ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Fainting Spells/Dizziness ☐ Yes ☐ No	Irregular Heartbeat ☐ Yes ☐ No	Sinus Trouble ☐ Yes ☐ No
Kidney Problems ☐ Yes ☐ No	Blood Transfusion ☐ Yes ☐ No	Leukemia ☐ Yes ☐ No	Stomach/Intestinal Disease ☐ Yes ☐ No
Breathing Problems ☐ Yes ☐ No	Frequent Headaches ☐ Yes ☐ No	Stroke ☐ Yes ☐ No	Bruise Easily ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No	Chemotherapy ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No	Chest Pains ☐ Yes ☐ No	Heart Attack/Failure ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No	Cold Sores/Fever Blisters ☐ Yes ☐ No	Heart Murmur ☐ Yes ☐ No	Pain in Jaw Joints ☐ Yes ☐ No
Congenital Heart Disorder ☐ Yes ☐ No	Heart Pacemaker ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No	Convulsions ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No	Wisdom Tooth Removal ☐ Yes ☐ No	

Have you ever had any serious illness not listed ☐ Yes ☐ No If yes _____

Person to be contacted in case of EMERGENCY (Name/Phone Number/Relationship) ☐ Yes ☐ No If yes _____

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: _____