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## Legacy Family Dental, P.C.

## Eaglesoft Medical History(PV)(Copy)(Copy)(Copy)

Patient Name:

Birth Date: Date Created:

Have you ever been hospitalized or had a major operation?  Have you sever had a serious head or neck injury?  Yes No If yes  Are you taking any medications, pills, or drugs?  Yes No If yes  Are you currently taking any blood thrining medication?  Yes No If yes  Are you currently taking any blood thrining medication?  Yes No If yes  Description of the special properation		Are you under a physician's care now?								
Very out taking any medications, pills, or drugs?   Very   No   If yes	Have you ever been hospit	alized or had	a major operati	on? O Yes	O No	If yes				
Are you currently taking any medications, pills, or drugs?  Yes No  If yes  Have you currently taking any blood thinning medication?  Yes No  If yes  Have you currently taking any blood thinning medication?  Yes No  If yes    Codene	Have you ever had a seriou	us head or ne	ck injury?		○ No	If yes				
Are you currently taking any blood thinning medication?  Yes No  If yes    Smokeless tobacco/Dip?	Are you taking any medicat	ions, pills, or	drugs?	0-200	277	PAGE 1				
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?    Quarettes?	## 9c//07/ab/		9: 10 :E	30	-	2. 700				
pregnant?   Smokeless tobacco/Dip?				9 (55)	0110					
Cgarettes?				other O Yes	O No	If yes				
men: Are you    Pregnant?	you use tobacco?									
Pregnant?   Trying to get pregnant?   Nursing?	Cigarettes?			E-Cigs/	/ape?			Smokeless	tobacco/Dip?	
Pregnant?   Trying to get pregnant?   Nursing?	omen: Are vou									
Aspirin Penicilin Codeine Sulfa Drugs Codeine Codeine Sulfa Drugs				☐ Trying t	o get preg	nant?		Nursing?		
Applyin Penicillin Codeine Subfa Drugs Codeine Acrylic Latex Sulfa Drugs Local Anesthetics Code you use controlled substances?  Yes No If yes Cortisone Medicine Yes No If yes Cortisone Medicine Yes No Alzheimer's Disease Yes No Diabetes Yes No Diabetes Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Emphysema Yes No Emphysema Yes No Emphysema Yes No Emphysema Yes No Excessive Thirst Yes No High Blood Pressure Yes No Remail Artificial Joint Yes No Excessive Thirst Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Frequent Diarrhea Yes No Enceptive Thirst Yes No Enceptive Thirst Yes No Enceptive Thirst Yes No Excessive Thirst Yes No Hypoglycemia Yes No Stoke William Yes In Excessive Thirst Yes No				7-310-330-74						
Oo you use controlled substances?  Yes No If yes  You have, or have you had, any of the following?  AIDS/HIV Positive Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Alahemer's Disease Yes No Diabetes Yes No Hepatitis A Yes No Recent Weight Loss Yes No Anaphylaxis Yes No Easily Winded Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Angina Yes No Emphysema Yes No Hepatitis B or C Yes No Renal Dialysis Yes No Arthritis/Gout Yes No Emphysema Yes No High Blood Pressure Yes No Recent Weight Loss Yes No Arthritis/Gout Yes No Emphysema Yes No High Blood Pressure Yes No Scarlet Fever Yes No Arthritis/Gout Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Asthrima Yes No Excessive Thirst Yes No Hypoglycemia Yes No Singles Yes No Blood Disease Yes No Frequent Cough Yes No Kidney Problems Yes No Stomach/Intestinal Disease Yes No Bruse Easily Yes No Genital Herpes Yes No Genital Herpes Yes No Cancer Yes No Genital Herpes Yes No Cancer Yes No Hay Fever Yes No Hay Fever Yes No Convusions Yes No Heart Turouble/Disease Yes No Convusions Yes No Heart Turouble/Disease Yes No Convusions Yes No Autoimmune Disease Yes No Dental Anxiety Yes No Developmental Delays Yes No Convusions Yes No Autoimmune Disease Yes No Dental Anxiety Yes No Sleep Apnea Yes No Sleep Apnea Yes No Developmental Delays Yes No Autoimmune Disease Yes No Dental Anxiety Yes No Sleep Apnea Yes No		following?	Peni	cillin			Codeine		Acrylic	
you have, or have you had, any of the following?  AIDS/HIV Positive	Metal		Late	x			Sulfa Drugs		Local Anesthetics	
AIDS/HIV Positive	Do you use controlled subst	tances?		O Yes	O No	If yes				
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 1 Anaphylaxis Yes No Drug Addiction Yes No Hepatitis B or C Yes No Renal Dialysis Yes 1 Anaphylaxis Yes No Renal Dialysis Yes No Dialysis Yes No Renal Dialysis Yes No Dialysis Yes No Dialysis Yes No Dialysis Yes No Dialysis Ye	you have, or have you ha	id, any of the	following?							
Anaphylaxis	AIDS/HIV Positive	O Yes	No Cortiso	ne Medicine	O Yes	O No	Hemophilia	Yes No	Radiation Treatments	O Yes O
Anemia Yes No Easily Winded Yes No Emphysema Yes No High Blood Pressure Yes No Reheumatism Yes No Arthficial Heart Valve Yes No Excessive Bleeding Yes No High Cholesterol Yes No Scarlet Fever Yes No Arthficial Joint Yes No Excessive Bleeding Yes No Hives or Rash Yes No Scarlet Fever Yes No Arthficial Joint Yes No Excessive Thirst Yes No Hives or Rash Yes No Scarlet Fever Yes No Scarlet Fever Yes No Arthficial Joint Yes No Frequent Cough Yes No Irregular Heartbeat Yes No Sinus Trouble Yes No Frequent Cough Yes No Kidney Problems Yes No Sinus Trouble Yes No Blood Dransfusion Yes No Frequent Cough Yes No Leukemia Yes No Stomach/Intestinal Disease Yes No Bruise Easily Yes No Genital Herpes Yes No Low Blood Pressure Yes No Stroke Yes No Chemotherapy Yes No Glaucoma Yes No Hay Fever Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Thyroid Disease Yes No Congenital Heart Disorder Yes No Heart Attack/Failure Yes No Pain in Jaw Joints Yes No Ucers No Pain in Jaw Joints Yes No Ucers No Heart Trouble/Disease Yes No Pain in Jaw Joints Yes No Ucers No Venereal Disease Yes No Venereal Disease Yes No Pelin Intellectual Disabilities Yes No Developmental Delays Yes No Autimmune Disease Yes No Dental Anxiety Yes No Sleep Apnea Yes No Sleep Apnea	Alzheimer's Disease	O Yes C	No Diabete	es	O Yes	O No	Hepatitis A	Yes No	Recent Weight Loss	O Yes O
Angina	Anaphylaxis	O Yes	No Drug A	ddiction	O Yes	○ No	Hepatitis B or C	Yes No	Renal Dialysis	O Yes O
Arthritis/Gout	Anemia	O Yes	No Easily V	Winded	O Yes	O No	Herpes	Yes No	Rheumatic Fever	Yes O
Artificial Heart Valve	Angina	O Yes	No Emphys	sema	O Yes	O No	High Blood Pressure	Yes No	Rheumatism	O Yes O
Artificial Joint	Arthritis/Gout	O Yes	No Epileps	y or Seizures	O Yes	O No	High Cholesterol	Yes No	Scarlet Fever	O Yes O
Asthma	Artificial Heart Valve	O Yes C	No Excess	ive Bleeding	O Yes	○ No	Hives or Rash	Yes No	Shingles	O Yes O
Blood Disease	Artificial Joint	O Yes C	No Excess	ive Thirst	O Yes	O No	Hypoglycemia	Yes No	Sickle Cell Disease	O Yes O
Blood Transfusion	Asthma	O Yes O	No Fainting	g Spells/Dizziness	O Yes	O No	Irregular Heartbeat	Yes No	Sinus Trouble	O Yes O
Breathing Problems	Blood Disease	O Yes	No Freque	nt Cough	O Yes	O No	Kidney Problems	Yes No	Spina Bifida	O Yes O
Bruise Easily	Blood Transfusion	O Yes O	No Freque	nt Diarrhea	O Yes	O No	Leukemia	Yes No	Stomach/Intestinal Disease	O Yes O
Cancer	Breathing Problems	O Yes	No Freque	nt Headaches	O Yes	O No	Liver Disease	Yes No	Stroke	O Yes O
Cancer	Bruise Easily	O Yes C	No Genital	Herpes			Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O
Chemotherapy Yes No Hay Fever Yes No Mitral Valve Prolapse Yes No Tonsillitis Yes O Chest Pains Yes No Heart Attack/Failure Yes No Osteoporosis Yes No Tuberculosis Yes O Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes O Congenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Yes O Convulsions Yes No Heart Trouble/Disease Yes No Psychiatric Care Yes No Venereal Disease Yes O Convolution Yes No ADD/ADHD Yes No Dental Anxiety Yes No Sleep Apnea Yes O Convention Yes No Sleep Apnea	Cancer		SERVICE DESCRIPTION	ma			Lung Disease		Thyroid Disease	
Chest Pains	Chemotherapy						W. Carlotte		763	
Cold Sores/Fever Blisters Yes No Heart Murmur Yes No Pain in Jaw Joints Yes No Tumors or Growths Yes Tongenital Heart Disorder Yes No Heart Pacemaker Yes No Parathyroid Disease Yes No Ulcers Yes Yes Yes Yes Yes No Parathyroid Disease Yes No Venereal Disease Yes No Autoimmune Disease Yes No Dental Anxiety Yes No Sleep Apnea							enance reaction and the Comment		The state of the s	
Congenital Heart Disorder			KO MENTER TO ACCOUNT OF	ANTHORNE THE PERSON IS			Carried to the second state		1. Production (1997) 4-26.	3 3
Convulsions	and the second second		SHEET: MANAGEMENT				CASSASSASSASSASSASSASSASSASSASSASSASSASS		THE CANADA WALL	100
Yellow Jaundice Yes No ADD/ADHD Yes No Intellectual Disabilities Yes No Developmental Delays Yes O Autoimmune Disease Yes No Dental Anxiety Yes No Sleep Apnea Yes O I			DAMES CONTRACTOR				All the second of the second o		Control Control	
Autism O Yes O No Autoimmune Disease O Yes O No Dental Anxiety O Yes O No Sleep Apnea O Yes O I	Convaisions			energia AE					et no contratt une que la coencie de la entre de	
	Vellow Taundice		00040000				Service configuration of the reservice		A CONTRACTOR OF THE CONTRACTOR	
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