Time 11:39 AM

Drs. Seymour,Parolli Trotter

Date 2/22/2018

Eaglesoft Medical History with PREMED(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Emergency Contact and Phone Number:		Comment
Has there been a change in your dental insurance, employer, address, or phone number?	Yes No	If yes
Are you under a physician's care now?	Yes No	If yes
Name and address of Physician	Yes No	If yes
Do you use tobacco? If yes, please specify smokeless, cigarettes, or vaping.	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Are any of your medications blood thinners or for osteoporosis?	Yes No	If yes

Are you sensitive or allergic to any of the following?

Aspirin	Yes No	Codeine	Yes No	Dental Anesthetics	Yes No
Jewerly/Metal	Yes No	Latex	Yes No	Penicillin	Yes No
Sulfa	Yes No				

Other Allergy?	Yes No	If yes
Have you been hospitalized or had a major operation in the last two years?	Yes No	If yes
Do you have any mental or physical limitation that might affect our ability to treat you? If yes, please explain.	Yes No	If yes
Has a doctor advised you to take an antibiotic prior to dental treatment? If yes, please explain and give name of doctor.	Yes No	If yes

Please mark yes to any of the following conditions that apply to your health.

Aids/HIV Positive	Yes No	Alzheimer's/Dementia	Yes No	Angina/Chest Pain	Yes No
Anemia	Yes No	Arthritis/Gout	Yes No	Artificial Heart Valve	Yes No
Artificial Joint	Yes No	Asthma/Breathing Problems	Yes No	Autism/Asperger's	Yes No
Auto Immune Disease	Yes No	Blood Disease Disorder	Yes No	Blood Transfusion	Yes No
Bruise Easily	Yes No	Cancer	Yes No	Chemotherapy	Yes No
Congenital Heart Disorder	Yes No	Convulsions	Yes No	Cortisone Medicine	Yes No
Currently Breast Feeding	Yes No	Diabetes	Yes No	Emphysema	Yes No
Epilepsy/Seizures	Yes No	Excessive Bleeding	Yes No	Excessive Thirst	Yes No
Fainting Spell/Dizziness	Yes No	Glaucoma	Yes No	Heart Attack/Failure	Yes No
Heart Murmur	Yes No	Heart Pace Maker	Yes No	Hepatitis A,B, or C	Yes No
Herpes	Yes No	High Blood Pressure	Yes No	High Cholesterol	Yes No
Irregular Heart Beat	Yes No	Kidney Problems	Yes No	Leukemia	Yes No
Liver Disease	Yes No	Lung Disease	Yes No	Mitral Valve Prolapse	Yes No
Pregnant/Trying	Yes No	Radiation Treatments	Yes No	Sickle Cell Disease	Yes No
Sjogren's Disease	Yes No	Stroke	Yes No	Substance Abuse	Yes No
Thyroid Disease	Yes No	Tuberculosis	Yes No	Tumors/Growths	Yes No

Do you have any other condition not listed above? 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:__________