Robin Y. Kwon DDS

Eaglesoft Medical History Page 1

Patient Name: Birth Date: Date Created:

Disclaimer

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 AT THIS TIME? PHYSICIAN NAME?	◯ Yes ◯ No	If yes	
HAVE YOU HAD ANY JOINT REPLACEMENTS, AND IF SO HAVE YOU TALKED TO YOUR DOCTOR ABOUT PREMEDICATION?	◯ 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 BLOOD THINNERS, AND IF SO WHAT IS YOUR CURRENT INR READING AND LAST DATE TAKEN?	◯ Yes ◯ No	If yes	
ARE YOU DIABETIC, AND IF SO WHAT TYPE? LAST A1C READING AND DATE TAKEN? WHAT IS A NORMAL READING	◯ Yes ◯ No	If yes	
DO YOU TAKE OR HAVE YOU TAKEN PHEN-FEN OR REDUX?	◯ Yes ◯ No	If yes	
HAVE YOU EVER TAKEN BISPOSPHOMATES?	◯ Yes ◯ No	If yes	
DO YOU SMOKE, OR HAVE YOU SMOKED IN THE PAST AND IF SO HOW MANY YEARS AND HOW MANY PER DAY?	◯ Yes ◯ No	If yes	
IF YOU SMOKE ARE YOU INTERESTED IN QUITTING?	◯ Yes ◯ No	If yes	
DO YOU CHEW TOBACCO, AND IF SO HOW MANY YEARS AND HOW MANY PER DAY?	◯ Yes ◯ No	If yes	
DO YOU USE MARIJUANA, AND IF SO WHAT PRODUCTS DO YOU USE?	◯ Yes ◯ No	If yes	
ARE YOU ALLERGIC TO ANYTHING? IF YES, PLEASE LIST AND REACTIONS.	◯ Yes ◯ No	If yes	
ARE YOU PREGNANT, NURSING OR TAKING ORAL CONTRACEPTIVES?	◯ Yes ◯ No	If yes	

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE #

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:_____

Time 11:46 AM

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Eaglesoft Medical History Page 2

Patient Name: Birth Date: Date Created:

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING

AIDS/ HIV POSITIVE	◯ Yes ◯ No	ALZHEIMER'S DISEASE	◯ Yes ◯ No	ANEMIA	◯ Yes ◯ No	ANGINA	◯ Yes ◯ No
ANXIETY	◯ Yes ◯ No	ARTHRITIS/ GOUT	◯ Yes ◯ No	ARTIFICIAL HEART VALVE	◯ Yes ◯ No	ARTIFICIAL JOINT	◯ Yes ◯ No
ASTHMA	◯ Yes ◯ No	BLOOD DISEASE	◯ Yes ◯ No	BLOOD TRANFUSION	◯ Yes ◯ No	BREATHING PROBLEMS	◯ Yes ◯ No
BRUISE EASILY	◯ Yes ◯ No	CANCER	◯ Yes ◯ No	CHEMOTHERAPY	◯ Yes ◯ No	CHEST PAINS	◯ Yes ◯ No
COLD SORES/ FEVER BLISTERS	◯ Yes ◯ No	CONGESTIVE HEART FAILURE	◯ Yes ◯ No	COVULSIONS	◯ Yes ◯ No	CORTISONE MEDICATION	◯ Yes ◯ No
DEMENTIA	◯ Yes ◯ No	DIABETES	◯ Yes ◯ No	DRUG ADDICTION	◯ Yes ◯ No	EASILY WINDED	◯ Yes ◯ No
EMPHYSEMA	◯ Yes ◯ No	EPILEPSY OF SEIZURES	◯ Yes ◯ No	EXCESSIVE BLEEDING	◯ Yes ◯ No	EXCESSIVE THIRST	◯ Yes ◯ No
FAINTING/ DIZZY SPELLS	◯ Yes ◯ No	FREQUENT COUGH	◯ Yes ◯ No	FREQUENT HEADACHES	◯ Yes ◯ No	HEART ATTACK/ FAILUR	◯ Yes ◯ No
HEART MURMER	◯ Yes ◯ No	HEART PACE MAKER	◯ Yes ◯ No	HEART TROUBLE/ DISEASE	◯ Yes ◯ No	HEMOPHELIA	◯ Yes ◯ No
HEPATITIS A	◯ Yes ◯ No	HEPATITIS B OR C	◯ Yes ◯ No	HERPES	◯ Yes ◯ No	HIGH BLOOD PRESSURE	◯ Yes ◯ No
HIGH CHOLESTEROL	◯ Yes ◯ No	HIVES OR RASH	◯ Yes ◯ No	HPV	◯ Yes ◯ No	HYPOGLYCEMIA	◯ Yes ◯ No
IRREGULAR HEARTBEAT	◯ Yes ◯ No	KIDNEY PROBLEMS	◯ Yes ◯ No	LEUKEMIA	◯ Yes ◯ No	LIVER DISEASE	◯ Yes ◯ No
LOW BLOOD PRESSURE	◯ Yes ◯ No	LUNG DISEASE	◯ Yes ◯ No	MITRAL VALVE PROLAPSE	◯ Yes ◯ No	OSTEOPOROSIS	◯ Yes ◯ No
PAIN IN JAW JOINTS	◯ Yes ◯ No	PARATHYROID DISEASE	◯ Yes ◯ No	PSYCHIATRIC CARE	◯ Yes ◯ No	RADIATION TREATMENT	◯ Yes ◯ No
RECENT WEIGHT LOSS	◯ Yes ◯ No	RENAL DIALYSIS	◯ Yes ◯ No	RHEUMATIC FEVER	◯ Yes ◯ No	RHEUMATISM	◯ Yes ◯ No
SCARLET FEVER	◯ Yes ◯ No	SINUS TROUBLE	◯ Yes ◯ No	SHINGLES	◯ Yes ◯ No	STOMACH/ INTESTINAL DISEASE	◯ Yes ◯ No
STROKE	◯ Yes ◯ No	SWELLING OF LIMBS	◯ Yes ◯ No	THYROID DISEASE	◯ Yes ◯ No		
TUBERCULOSIS	◯ Yes ◯ No	TUMORS OR GROWTHS	◯ Yes ◯ No	VENEREAL DISEASE	◯ Yes ◯ No	TONSILITIS	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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Signature of Patient, Parent or Guardian:

X Date:_____