X

Brian C. McGue, D.D.S. **Eaglesoft Medical History**

Patient Name:

Birth Date:

Date Created:

Date:_

Are you under a physici'-	care now?				7.5						
Are you under a physician's care now? Have you ever been hospitalized or had a major operation?				○ No	If yes						
There you ever been nospitalized of flad a finator operation?			(Yes	○ No	If yes						
Have you ever had a serious head or neck injury?			O Yes	○ No	If yes						33.00
Are you taking any medications, pills, or drugs?				O No	If yes						
Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			O Yes	_	If yes If yes						
			O Yes								
Are you on a special diet?				O No							
Do you use tobacco? Do you use controlled substances?				O Yes O No							
				O No	If yes			Juli			
omen: Are you											
Pregnant/Trying to get p	regnant?		Nursin	g?			Tal	cing oral	contraceptives?		
e you allergic to any of the f	following?										
Aspirin						Codeine			Acrylic		
Metal		Latex				Sulfa Drugs			Local Anesthetics		
Other?					If yes						
you have, or have you had						T.,			In		
AIDS/HIV Positive	O Yes O No	Cortisone Med	idne	O Yes	-	Hemophilia	O Yes	-	Radiation Treatments	(Yes	-
Alzheimer's Disease	O Yes O No	Diabetes		O Yes	O No	Hepatitis A	(Yes		Recent Weight Loss	O Yes	
Anaphylaxis	O Yes O No	Drug Addiction		O Yes		Hepatitis B or C	O Yes		Renal Dialysis	(Yes	
Anemia	O Yes O No	Easily Winded		() Yes	_	Herpes	O Yes		Rheumatic Fever	(Yes	_
Angina	O Yes O No	Emphysema		(Yes	_	High Blood Pressure	O Yes	-	Rheumatism	O Yes	-
Arthritis/Gout	O Yes O No	Epilepsy or Se		() Yes		High Cholesterol	O Yes	_	Scarlet Fever	O Yes	-
Artificial HeartValve	O Yes O No	Excessive Blee		() Yes	-	Hives or Rash	O Yes	-	Shingles Sickle Cell Disease	O Yes	
Artificial Joint	O Yes O No	Excessive Thirs		(Yes		Hypoglycemia	(Yes	_	Sinus Trouble	O Yes	_
Asthma	O Yes O No	Fainting Spells		(Yes		Irregular Heartbeat	O Yes	_	Spina Bifida	O Yes	_
Blood Disease	O Yes O No	Frequent Coug		(Yes	_	Kidney Problems	O Yes	-	Stomach/Intestinal Disease	O Yes	
Blood Transfusion	O Yes O No	Frequent Diarr		(Yes		Leukemia	O Yes		Stroke	() Yes	
Breathing Problems	O Yes O No	Genital Herpes	acnes	O Yes	1000	Liver Disease Low Blood Pressure	O Yes		Swelling of Limbs	O Yes	-
Bruise Easily	O Yes O No	Glaucoma		O Yes		Lung Disease	Yes Yes		Thyroid Disease	() Yes	
Chamatharam	O Yes O No	Hay Fever			O No	Mitral Valve Prolapse	() Yes		Tonsillitis	() Yes	
Chemotherapy Chest Pains	O Yes O No	Heart Attack/F	ailure		○ No	Osteo porosis	() Yes		Tuberculosis	O Yes	
Cold Sores/Fever Blisters	Yes No	Heart Murmur	unuic		O No	Pain in Jaw Joints	() Yes		Tumors or Growths	(Yes	_
Congenital Heart Disorder	O Yes O No	Heart Pacemal	er		O No	Parathyroid Disease	O Yes	-	Ulcers	① Yes	
Convulsions	O Yes O No	Heart Trouble		-	() No	Psychiatric Care	() Yes		Venereal Disease	O Yes	-
	0.11								YellowJaundice	() Yes	O N
Have you ever had any seri	ous illness not lis	ted above?	() Yes	() No	If yes			Lotes			
omments:											
the best of my knowledge, to ponsibility to inform the den	he questions on t tal office of any cl	his form have beer nanges in medical :	accurate tatus.	ly answered	d. I under	stand that providing incorre	ect informatio	on can be	dangerous to my (or patient's)	nealth.	It is my