Time 10:23 AM

Baccellieri Family Dentistry LLC

Date 11/12/2026

Eaglesoft Medical History(2026)(Copy)

Patient Name: Birth Date: Date Created:

General Single Questions

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
Do you take or have you taken Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Do you take or have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you take or have you ever taken a GLP (Ozempic, Wagovy, Moujaro, etc.)?	◯ Yes ◯ No	
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes

Women: Are you...

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

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

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	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No
Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems/Asthma	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No
Tonsilitis	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ 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	Psychiatric Care	◯ Yes ◯ No	HPV	◯ Yes ◯ No		

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

Comments:

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:_____