Date 9/23/2020

NEAL J. POSTEL, D.D.S. Eaglesoft Medical History

Birth Date:

Date Created:

Patient Name:

: Are you under a physician'											ре такіп
				0,, ,00	, , , , , , , , , , , , , , , , , , ,	rt of your entire body. Hea					
	Are you under a physician's care now?				If yes						
Have you ever been hospitalized or had a major operation?				○ No	If yes						
Have you ever had a serio	us head o	r neck in	iury? (Yes	○ No	If yes						
Are you taking any medications, pills, or drugs? Do you take, or have you taken, Phen-Fen or Redux? Have you ever taken Fosamax, Boniva, Actonel or any other				○ No	If yes	5					
				○ No		S. Control of the con					
				O No	If yes						
medications containing bis		nates?				5.,					
Are you on a special diet?		○Yes									
Do you use tobacco?		120	○Yes ○No		-						
Do you use controlled substances?				○ No	If yes					azva bi 4 bi ili ağırı bi a cürcü bi ba	
/omen: Are you Pregnant/Trying to get	pregnant?	>	Nursi	ng?			□Та	king ora	contraceptives?		
re you allergic to any of the	following?										
Aspirin			hand it is a second of the sec			Codeine			Acrylic		
Metal			Latex			Sulfa Drugs			Local Anesthetics		
Other?					If yes						
you have, or have you ha	d, any of	the follow	ino?								
AIDS/HIV Positive	○Yes		Cortisone Mediane	○ Yes	○ No	Hemophilia	○ Yes	O No	Radiation Treatments	○Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Diab etes	○ Yes	○ No	Hepatitis A	○ Yes	O No	Recent Weight Loss	○ Yes	○No
Anaphylaxis	○ Yes	○ No	Drug Addiction	○ Yes	○ No	Hepatitis B or C	○ Yes	O No	Renal Dialysis	○ Yes	ONo
Anemia	○Yes	○ No	Easily Winded	○ Yes	○No	Herpes	○ Yes	O No	Rheumatic Fever	○ Yes	O No
Angina	○ Yes	○ No	Emphysema	○ Yes	○ No	High Blood Pressure	○ Yes	O No	Rheumatism	○ Yes	○ No
Arthritis/Gout	○ Yes	O No	Epilepsy or Seizures	○ Yes	○No	High Cholesterol	○ Yes	○ No	Scarlet Fever	○ Yes	O No
Artificial Heart Valve	○ Yes	O No	Excessive Bleeding	O Yes	○ No	Hives or Rash	○Yes	O No	Shingles	○ Yes	
Artificial Joint	○ Yes	○ No	Excessive Thirst	○ Yes	○ No	Hypoglycemia	○ Yes	19 <u>2</u> 5	Sickle Cell Disease	○ Yes	
Asthma	Yes	-	Fainting Spells/Dizziness		1977	Irregular Heartbeat	○ Yes		Sinus Trouble	○ Yes	
Blood Disease	○ Yes	0.220	Frequent Cough	○ Yes	August 1	Kidney Problems	○Yes		Spina Bifida	○ Yes	
Blood Transfusion	○ Yes	2	Frequent Diarrhea	() Yes	0.00	Leukemia	○Yes	7.7 <u>2.</u> 71	Stomach/Intestinal Disease	○ Yes	222
Breathing Problems	○ Yes	-	Frequent Headaches		○No	Liver Disease	○ Yes		Stroke Swelling of Limbs	○ Yes	
Bruise Easily	○ Yes ○ Yes		Genital Herpes Glaucoma	○ Yes	○ No	Low Blood Pressure	○ Yes ○ Yes	-55-51	Thyroid Disease	○ Yes ○ Yes	770
Chamatharan	○ Yes		Hay Fever		○No	Lung Disease Mitral Valve Prolapse	○ Yes		Tonsillitis	O Yes	
Chemotherapy Chest Pains	○ Yes		Heart Attack/Failure	○ Yes		Osteoporosis	O Yes		Tuberculosis	○ Yes	
Cold Sores/Fever Blisters	○ Yes		Heart Murmur	○ Yes	200 - 100 - 100 C	Pain in Jaw Joints	O Yes		Tumors or Growths	○ Yes	1776
Congenital Heart Disorder	1227		Heart Pacemaker		○ No	Parathyroid Disease	○ Yes	7.000	Ulcers	○ Yes	
Convulsions	() Yes		Heart Trouble/Disease		○ No	Psychiatric Care	○ Yes		Venereal Disease	○ Yes	
				-		78 11			Yellow Jaundice	○Yes	ONo
Have you ever had any ser	ious illnes	ss notlis	l ted above? OYes	○ No	If yes						
omments:											
Have you ever had any ser	ious illnes	ss notlis	ted above? O Yes	O No	If yes						