WILLIAM E. WYATT JR.
DDS
TRULY GENTLE, EXCEPTIONAL DENTISTRY

Medical History

Patient Name _____

Medical Doctor _____ Phone_____

Most Recent Physical Examination _____ Purpose _____

What is your estimate of your general health? _____

Have you or anyone in your household had COVID-19? _____

When? _____ Are you, or have you had a fever in the last 24 to 48 hours? _____

Have you or anyone in your household been out of the state or country in the last 7 to 14 days? Yes or No

If yes, please explain _____

****PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS, INCLUDING OVER THE COUNTER, YOU ARE TAKING.****

Have you ever been hospitalized for an illness or injury? Yes or No

Please List _____

Have you ever had an Allergic Reaction to Any Medications? Yes or No

Please List _____

Are you presently being treated for any illness? Yes or No

Please List _____

Are you aware of a change in your overall general health? Yes or No

Please List _____

Please **LIST** all medications you take _____

_____

2717 Cross Timbers Rd. Ste 424 Flower Mound, Texas 75028
Phone (972) 355-2222 Fax (972) 355-3234
www.FlowerMoundDental.com

HAVE YOU EVER HAD THE FOLLOWING?

	Y	N		Y	N		Y	N
Heart Problems			Glaucoma			Emotional Problems		
Heart Murmur			Contact Lens			Psychiatric Problems		
Rheumatic Fever			Head or Neck Injuries			Antidepressant Medication		
Scarlet Fever			Epilepsy, Convulsions, Seizures			Alcohol / Drug Dependency		
Abnormal Blood Pressure			Viral Infections & Cold Sores			Often Exhausted or Fatigued		
Stroke			Hives, Skin Rash, Hay Fever			Subject to Frequent Headaches		
Artificial Prosthesis (Heart Valve or Joints)			Hepatitis List Type _____			Considered a touchy Person		
Anemia or other Blood Disorder			HIV / AIDS			Often Unhappy or Depressed		
Prolonged bleeding due to slight cut			Tumor / Abnormal Growth			Easily Upset or Irritated		
Emphysema			Radiation Therapy			Stomach or Duodenal Ulcer		
Tuberculosis			Chemotherapy			Digestive Disorders		
Asthma			Thyroid or Parathyroid Disease			Arthritis		
Sinus Problems			Hormone Deficiency			Liver Disease		
Kidney Disease			High Cholesterol			Jaundice		
Diabetes			Any Lumps or Swelling in the Mouth			Venereal Disease		

Do you Smoke, Vape, or use Electronic Nicotine? Yes or No How Many Years? _____

FEMALE: Taking Birth Control Pills? Yes or No Pregnant? Yes or No How Far Along?_____

MALE: Prostate Disorders? Yes or No Do you take ED medication? Yes or No

Please describe **ANY OTHER** medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. _____

_____

Patient's Signature _____ Date _____

2717 Cross Timbers Rd. Ste 424 Flower Mound, Texas 75028
Phone (972) 355-2222 Fax (972) 355-3234
www.FlowerMoundDental.com