DentistTree
931 S Erby Campbell Blvd
Royse City, TX 75189

(972)635-3747
dentisttreetx@gmail.com
www.Dentisttreetx.com

# Medical History

Patient Name: ______ ______ ______ ______
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

- [ ] Ever been hospitalized (illness or injury)
- [ ] Presently being treated for any other illnesses
- [ ] Subject to frequent headaches
- [ ] Tobacco/Alcohol Use
- [ ] FEMALE: Taking birth control pills
- [ ] FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

Do you have any medication allergies? If yes, please list.

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Response Date: