GrapevineKids
DENTAL AND ORTHODONTICS

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Medical History

PERSONAL INFORMATION

Patient Name : _____ DOB: _____

DENTAL INFORMATION

Are you having any pain or sensitivity at this time (or recently)? ____ No ____ Yes
If yes, please explain:

_____

Do you have any dental problems right now that you are aware of? No Yes
If yes, please explain:

_____

MEDICAL INFORMATION

Is the patient pregnant ? ____ No ____ Yes
Are you being treated by a physician now? ____ No ____ Yes
Reason: _____
Taking any medications? ____ No ____ Yes
Identify: _____
Allergic to any medications? ____ No ____ Yes
Identify: _____
Allergic to metals? ____ No ____ Yes Identify:_____
Any recent serious illnesses? ____ No ____ Yes Identify: _____
Have you ever had any major surgery? ____ No ____ Yes Identify: _____

Please CIRCLE any of the following which you have had (or presently have).

Heart Problems	Stroke	High Blood Pressure	Diabete	Tuberculosis
Asthma	Epilepsy	Hepatitis	Thyroid	Bronchitis
Stomach/Intestinal Problems		Heart Murmur	Kidney Problems	Pink Eye
Prolonged Bleeding	Fainting/Dizzy	Liver Disorder	Pneumonia	Abnormal Bleeding
Anemia	Arthritis	Bone Disorder	Nervous Disorder	Cancer / Tumors

Are there any other medical problems that we should be aware of? ____ No ____ Yes
If yes, please
explain:_____
The information above is accurate to the best of my knowledge.
X _____ (Signature) Date: _____