E-mail Form | Print Form

Name: _____ Nickname: _____ **Date:** _____

If minor, who accompanied: _____ Who suggested you see an orthodontist? _____
School/Employer: _____ Interests: _____

Siblings (Name & Age)					
Orthodontic Tmt done?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Medical History

Physician's Name: _____

Indicate yes or no if you have or have had problems with any of the following:

AIDS/HIV	☐Yes ☐No	Emphysema	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Anemia	☐Yes ☐No	EDS (Ehlers-Danlos)	☐Yes ☐No	Neurological Probs.	☐Yes ☐No
Arthritis	☐Yes ☐No	Epilepsy	☐Yes ☐No	Pacemaker	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Fibromyalgia	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Headaches	☐Yes ☐No	Respiratory Problems	☐Yes ☐No
Asthma or Hay fever	☐Yes ☐No	Heart Problems	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Bleeding (abnormal)	☐Yes ☐No	Explain:_____	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Blood Disease	☐Yes ☐No	Hemophilia	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis Type___	☐Yes ☐No	Seizures	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Herpes	☐Yes ☐No	Skin Rash	☐Yes ☐No
Chemotherapy	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Circulatory Problems	☐Yes ☐No	HIV Positive	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No
Cortisone Treatments	☐Yes ☐No	Leukemia	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Liver Disease	☐Yes ☐No		

Have you ever taken any of these medications?

Diet Medications:	☐Dexfenfluramine	☐Fen-phen	☐Pondimin	☐Redux
Blood Thinners:	☐Coumadin	☐Warfarin		
Bisphosphonates (typically for tmt of cancer or osteoporosis):	☐Didrone ☐Actonel	☐Skelid ☐Boniva	☐Aredia ☐Zometa	☐Fosamax
Other:	☐Levoxyl	☐Synthroid		

MEDICATIONS
List any medications you are taking & why (including vitamins, supplements, herbs or over the counter medications)

_____

_____

ALLERGIES (things you can't have)

☐Penicillin Other:_____
☐Sulfa _____
☐Latex _____

Please list any operations you have had:_____

DENTAL HISTORY

Dentist's Name: _____
Last Visit: _____

Indicate yes or no if you have or have had problems with any of the following:

Clicking or popping jaw	☐Yes ☐No	Missing any teeth	☐Yes ☐No	Periodontal probs/tmt.	☐Yes ☐No
Injury to teeth, mouth or jaw	☐Yes ☐No	Grind/clench teeth	☐Yes ☐No	Habits:_____	☐Yes ☐No
Head, neck or ear pain	☐Yes ☐No	Tobacco use/smoke	☐Yes ☐No	_____	
Jaw pain or tiredness	☐Yes ☐No	Bad gag reflex	☐Yes ☐No	_____	

Chief Concern(s): _____

I the undersigned, have given the above dental and medical information, and it is accurate to the best of my knowledge. If there changes to this information in the future, I will so inform this practice. I hereby authorize the taking of X-rays and other records for an initial diagnosis if needed.

_____ Is your child adopted? ☐Yes ☐No _____
Signature (Patient/Responsible Adult) Today's Date

This information has been reviewed by: _____ Date: _____

Straight Line Orthodontics, Inc.