



SUMMIT FAMILY
ORTHODONTICS

PATIENT NAME: _____

DATE: _____

PLEASE CHECK ALL THAT APPLY

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Blood Disease
- ☐ Abnormal Bleeding
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Trouble

- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Jaw Popping
- ☐ Limited Mouth Opening
- ☐ Ringing Ears
- ☐ Posture Problems
- ☐ Clenching
- ☐ Grinding
- ☐ Facial Pain
- ☐ Neck Ache
- ☐ Pregnancy
- ☐ Heart Problems: _____
- ☐ Neurological Problems: _____
- ☐ Artificial Joints: _____

- ☐ Tumors: _____
- ☐ TMJ soreness, popping, pain: _____
- ☐ Sleep apnea, snoring, CPAP, or a sleep study: _____
- ☐ Speech Problems: _____
- ☐ Thumb Sucking: _____
- ☐ Injury to Face or Jaws: _____
- ☐ Pregnant or trying to become pregnant: _____
- ☐ Any other Medical Problems: _____

Please list **ALL** current medications with dosages:

Please list **ALL** known allergies:

Are you currently being monitored by a health care physician? ____yes ____no

Name of office(s) or doctor(s):

Have you ever needed antibiotics or any other medication prior to dental treatment? ____yes ____no

If yes, which medication? _____

Have you ever taken or are you currently taking medications for osteoporosis or cancer (bisphosphonates)? Ex. Fosamax, Actonel, or Boniva.

☐ No ☐ Yes

If yes, please specify: _____

If yes, for how long?: _____

If you are not currently taking the medication, when did you stop taking it? _____

The information I have given is correct to the best of my knowledge. I understand that I must inform the office of any changes to my medical status.

Signature: _____

Date: _____