

# DOBBIN DENTAL SUITE

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WELCOME TO OUR OFFICE			DATE: / /
NAME (FIRST, MIDDLE, LAST)	AGE	DATE OF BIRTH	
ADDRESS/CITY/STATE/ZIP		WHOM MAY WE THANK FOR REFERRING YOU?	
HOME PHONE NUMBER	WORK PHONE NUMBER	MOBILE PHONE NUMBER	
SOCIAL SECURITY NUMBER	MARITAL STATUS	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
PHYSICIAN NAME:		PHYSICIAN PHONE NUMBER	
HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT WAS THE ILLNESS OR PROBLEM?	
<b>ARE YOU TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICINE(S)?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, PLEASE LIST ALL, INCLUDING VITAMINS, NATURAL OR HERBAL PREPARATIONS, AND/OR DIETARY SUPPLEMENTS) <b>LIST MEDICATION NAME AND DOSAGE</b>			
<b>ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES</b> <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE AND TYPE OF REACTION):			

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS			
PLEASE CHECK IF <b>YOU</b> HAVE BEEN DIAGNOSED OR ARE CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING:			
<input type="checkbox"/> 1. HIGH BLOOD PRESSURE <input type="checkbox"/> 2. CARDIOVASCULAR DISEASE <input type="checkbox"/> 3. HEART ATTACK <input type="checkbox"/> 4. CHEST PAIN / ANGINA <input type="checkbox"/> 5. PALPITATIONS <input type="checkbox"/> 6. ARTIFICIAL (PROSTHETIC) HEART VALVE <input type="checkbox"/> 7. PREVIOUS INFECTIVE ENDOCARDITIS <input type="checkbox"/> 8. DAMAGED VALVES IN TRANSPLANTED HEART <input type="checkbox"/> 9. ORGAN TRANSPLANT <input type="checkbox"/> 10. CONGENITAL HEART DISEASE <input type="checkbox"/> 11. CONGESTIVE HEART FAILURE <input type="checkbox"/> 12. PACEMAKER <input type="checkbox"/> 13. DIABETES <input type="checkbox"/> 14. CANCER / CHEMO / RADIATION	<input type="checkbox"/> 15. BLEEDING PROBLEMS <input type="checkbox"/> 16. TAKING BLOOD THINNERS <input type="checkbox"/> 17. ANEMIA <input type="checkbox"/> 18. ARTHRITIS <input type="checkbox"/> 19. AUTOIMMUNE DISEASE <input type="checkbox"/> 20. RHEUMATOID ARTHRITIS <input type="checkbox"/> 21. SYSTEMIC LUPUS ERYTHEMATOSUS <input type="checkbox"/> 22. EMPHYSEMA <input type="checkbox"/> 23. SINUS TROUBLE <input type="checkbox"/> 24. TUBERCULOSIS <input type="checkbox"/> 25. EATING DISORDER <input type="checkbox"/> 26. GASTROINTESTINAL DISEASE <input type="checkbox"/> 27. REFLUX / HEARTBURN <input type="checkbox"/> 28. ULCERS <input type="checkbox"/> 29. THYROID PROBLEMS	<input type="checkbox"/> 30. STROKE <input type="checkbox"/> 31. GLAUCOMA <input type="checkbox"/> 32. HEPATITIS OR JAUNDICE <input type="checkbox"/> 33. LIVER DISEASE <input type="checkbox"/> 34. EPILEPSY <input type="checkbox"/> 35. FAINTING SPELLS OR SEIZURES <input type="checkbox"/> 36. HEAD OR NECK RADIATION <input type="checkbox"/> 37. HEADACHE / MIGRAINES <input type="checkbox"/> 38. KIDNEY PROBLEMS <input type="checkbox"/> 39. OSTEOPOROSIS; TAKING ORAL BISPHOSPHONATES, IE. FOSAMAX <input type="checkbox"/> 40. RECURRENT INFECTIONS <input type="checkbox"/> 41. HIV OR AIDS INFECTION <input type="checkbox"/> 42. SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/> 43. ALCOHOL ABUSE <input type="checkbox"/> 44. DRUG ABUSE <input type="checkbox"/> 45. TOBACCO USE IF YES, SPECIFY: _____ <input type="checkbox"/> 46. WEAR CONTACT LENSES  WOMEN ONLY: <input type="checkbox"/> 47. PREGNANT <input type="checkbox"/> 48. NURSING <input type="checkbox"/> 49. TAKING HORMONE REPLACEMENT <input type="checkbox"/> 50. TAKING BIRTH CONTROL MEDICATION <input type="checkbox"/> 51. FERTILITY TREATMENTS  OTHER:
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Joint Replacement. Have you had an orthopedic total joint replacement? <input type="checkbox"/> YES <input type="checkbox"/> NO   Location/Type: _____ Date of Surgery: _____   If yes, was premedication recommended?			
Were you treated or scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO   If yes, date treatment began: _____			