INSTRUCTIONS TO THE PATIENT:
Answer the following questions as completely and accurately as possible. All information is CONFIDENTIAL. Please circle “YES” or “NO” to all questions, and write in your answers as appropriate.

1. Are you under the care of a physician at this time? YES NO
   If yes, for what condition? ________________________________

2. The name and address of my physician is: ________________________________________________________________

3. Your last physical examination was on ______________________.

4. Has a physician treated you in the past six months? YES NO
   If yes, for what condition? ________________________________

5. Have you been hospitalized or have a serious illness (including MRSA infection) within the last five years? YES NO
   If yes, please specify: ____________________________________________________________

6. Are you allergic or had any adverse reaction to any medicines, drugs, local anesthetics, LATEX or other substances? YES NO
   If yes, please specify: ____________________________________________________________

7. Do you now or have you ever smoked cigarettes or used tobacco products? YES NO
   If yes, please specify: Number of packs/day________  Number of years:________

8. Do you have or have you had any of the following diseases/problems? Please explain “YES” answers on the back.

   A. Abnormal bleeding, bruise or history of transfusion. Taking aspirin or blood thinner. YES NO
   B. Lung/Respiratory condition (asthma, bronchitis, emphysema). YES NO
   C. Diabetes. YES NO
   D. Emotional/Mental health disorder (anxiety, depression, bipolar disorder). YES NO
   E. Epilepsy/Seizures/Convulsions. YES NO
   F. Liver disease (Hepatitis/Jaundice/Cirrhosis). YES NO
   G. High blood pressure. YES NO
   H. HIV positive/AIDS. YES NO
   I. Hives, itching or skin rash. YES NO
   J. Kidney/Renal disease. YES NO
   K. Sexually Transmitted Disease(s). YES NO
   L. Stomach ulcers. YES NO
   M. Thyroid disease. YES NO
   N. Tuberculosis. YES NO
   O. Artificial/Prosthetic joint replacement (knee or hip). YES NO
   P. Angina/Chest pain, Shortness of breath. YES NO
   Q. Artificial/Prosthetic heart valves. Date:________________________ YES NO
   R. Valve damage following heart transplant. YES NO
   S. Congenital heart disease. YES NO
   T. Infective endocarditis (heart infection) . YES NO
   U. Heart attack Date:________________________ YES NO
   V. Heart surgery Date: ______________________ YES NO
   W. Stroke Date: ______________________ YES NO
   X. Congestive heart failure. YES NO
   Y. Coronary artery or other heart disease. YES NO
   Z. Arteriosclerosis/Coronary occlusion. YES NO
   AA. Pacemaker. YES NO
   BB. Implanted cardio-defibrillator. YES NO
   CC. Immune suppression or deficiency. YES NO
   DD. Cancer/Chemo/Radiation therapy. YES NO
   EE. Drug abuse (cocaine methamphetamine, heroin, crack) or drug rehabilitation. YES NO
   FF. Alcohol abuse (alcohol rehabilitation). YES NO

LETTER EXPLANATION FOR QUESTION 8

Turn Over
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? .................. YES NO
   If yes, please list: __________________________________________________________________________________________

10. Do you have any other diseases, conditions, or problems not listed above? If yes, please explain: ...................... YES NO

<table>
<thead>
<tr>
<th>OTHER CONDITION</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. Are you taking or have you ever taken any medications, (examples below), either orally or by injection, for osteoporosis, osteopenia or bone loss due to aging OR lung cancer, breast cancer, prostate cancer, colorectal cancer, wet macular degeneration, Paget’s Disease, or multiple myeloma?
   Examples: Fosamax® (alendronate); Boniva® (ibandronate); Actonel® (risedronate); Reclast® yearly injection (zoledronic acid); Aredia® (pamidronate); Zometa® (zoledronic acid); Bonefos® (clodronate); Avastin® (bevacizumab); Erbitux® (cetuximab); Herceptin® (trastuzumab)
   If yes, please list the appropriate medication below:
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

12. Please list any premedication, medications, pills, or drugs with dosage which you are taking both prescription and nonprescription (Must be completed the DAY OF THE EXAMINATION)

<table>
<thead>
<tr>
<th>MEDICATION/DOSAGE</th>
<th>REASON PRESCRIBED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

13. WOMEN ONLY: Are you pregnant? ...................................................................................................................... YES NO
    If yes, when is your expected due date? __________________________________________________________________
    Are you currently breast feeding? ...................................................................................................................... YES NO

14. AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA) CLASSIFICATION ............................................................... CLASS ______________
    (ASA I: Normal healthy patient; ASA II: Patient with mild systemic disease; no functional limitation–e.g., smoker with well-controlled hypertension; ASA III: Patient with severe systemic disease; definite functional impairment–e.g., diabetes mellitus (DM) and angina pectoris with relatively stable disease, but requiring therapy)

Any item on the Medical History with a “YES” response, in questions #4-13 could require a Medical Clearance from a licensed physician if the explanation section indicated the possibility of a systemic condition that could affect the patient’s suitability for elective dental treatment during the examination. The Medical Clearance must include the physician’s name, address, and phone number.

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold the testing agency responsible for any action taken or not taken because of errors I may have made when completing this form.

PATIENT SIGNATURE: ________________________________
DATE SIGNED: ________________

CANDIDATE INITIALS: ________
DATE INITIALED: ________________

CANDIDATE SIGNATURE: ________________________________ (Added at end of exam) 75