Medical History Form

Candidate Sequential:_____
Candidate ID:
PLACE ID LABEL HERE
Test Site:_____

Place ID label above. If you do not have an ID label, write in the corresponding numbers from your ID card on the lines above

Cubicle #:

Patient's name_____ **Date Form Completed** _____/_____/_____

Birthdate _____/_____/_____ **Weight** _____

Examiner Confirms BP Taken Day of Exam | | | | | |

Blood Pressure _____ **Date/Time Taken** _____

Required – Must Be Taken Day of Examination

Examiner Confirms Radiographs Appropriate | | | | | |

Examiner Number

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

LETTER	EXPLANATION FOR QUESTION 8

Turn Over →

LETTER	EXPLANATION FOR QUESTION 8 (Continued)

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**

OTHER CONDITION	EXPLANATION

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?..... **YES NO**

    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**)

MEDICATION/DOSAGE	REASON PRESCRIBED
1.	
2.	
3.	
4.	
5.	

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 Sequential:____

Candidate ID

PLACE ID LABEL HERE

Test Site:____

CANDIDATE SIGNATURE: _____