

# Medical History Form

Candidate Sequential: \_\_\_\_\_  
**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 \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight \_\_\_\_\_

Date Form Completed \_\_\_\_/\_\_\_\_/\_\_\_\_

Examiner Confirms BP Taken Day of Exam

Examiner Confirms Radiographs Appropriate

Examiner Number

Blood Pressure \_\_\_\_\_ Date/Time Taken \_\_\_\_\_  
Required – Must Be Taken Day of Examination

## 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.

- Are you under the care of a physician at this time? ..... **YES NO**  
 If yes, for what condition? \_\_\_\_\_
- The name and address of my physician is: \_\_\_\_\_
- Do you have or have you had any of the following diseases/problems? Please explain "YES" answers on the back.

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

LETTER	EXPLANATION FOR QUESTION 3 OR ANY OTHER CONDITIONS NOT LISTED ABOVE

- Have you recently experienced symptoms associated with COVID-19 (cough, difficulty breathing, body aches, fever)?.....**YES NO**  
 If you tested positive for COVID-19, have you subsequently tested negative twice after symptoms disappeared?..... **N/A YES NO**
- Are you taking or have you ever taken any bisphosphonate medications, either orally or by injection, for osteoporosis, osteopenia, or bone loss due to aging OR a bone wasting disease such as prostate, breast, or lung cancer or Paget's disease?.....**YES NO**
- Are you allergic or have you had any adverse reactions to any medications, drugs, local anesthetics, LATEX or other substances?  
**YES NO**  
 If yes, please specify: \_\_\_\_\_

Turn Over →

7. 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.	

8. **WOMEN ONLY:** Are you pregnant? ..... **YES NO**  
 If yes, when is your expected due date? \_\_\_\_\_  
 Are you currently breast feeding?..... **YES NO**

**Any item on the Medical History with a "YES" response, in questions #3-8 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.**

9. **HEAD, NECK, AND ORAL EXAMINATION**

Note Findings of the Examination			Candidate Remarks on Findings
a. Ulcers or pigmentation of the lips	<b>YES</b>	<b>NO</b>	_____
b. Abnormal masses on palpation of the salivary glands or lymph nodes	<b>YES</b>	<b>NO</b>	_____
c. Yellowing of oral mucosa	<b>YES</b>	<b>NO</b>	_____
d. Bluish or white patches on oral mucosa	<b>YES</b>	<b>NO</b>	_____
e. Red or pigmented areas on oral mucosa	<b>YES</b>	<b>NO</b>	_____
f. Vesicles or bullae on oral mucosa	<b>YES</b>	<b>NO</b>	_____
g. Oral ulcers	<b>YES</b>	<b>NO</b>	_____
h. Abnormal oral masses	<b>YES</b>	<b>NO</b>	_____

10. **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)

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:** \_\_\_\_\_

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**CANDIDATE SIGNATURE:** \_\_\_\_\_

(Added at end of exam)