Patient Health History Form

Signature of Patient			Date
Birthday	Weight	Blood Pressure	Date/Time Taken
Signature of Witness			Date

Examiner Confirms

BP Taken Day of Exam

Required – Must Be Taken Day of Examination 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

B. Artificial/Prosthetic heart valves: YES NO Date: _____

C. Lung/Respiratory condition (asthma, bronchitis, emphysema): YES NO

D. Valve damage following heart transplant: YES NO

E. Diabetes: YES NO

F. Congenital heart disease: YES NO

G. Emotional/Mental health disorder (anxiety, depression, bipolar disorder): YES NO

H. Infective endocarditis (heart infection): YES NO

I. Epilepsy/Seizures/Convulsions: YES NO

J. Heart Attack: YES NO Date: _____

K. Liver disease (Hepatitis/Jaundice/Cirrhosis): YES NO

L. Heart Surgery: YES NO Date: _____

M. High blood pressure: YES NO

N. Stroke Date: YES NO

O. HIV Positive/AIDS: YES NO

P. Congestive Heart Failure: YES NO

Q. Hives, Itching or Skin Rash: YES NO

R. Coronary artery or other heart disease: YES NO

S. Kidney/Renal disease: YES NO

T. Arteriosclerosis/Coronary occlusion: YES NO

U. Sexually Transmitted Disease(s): YES NO

V. Pacemaker: YES NO

W. Stomach Ulcers: YES NO

X. Implanted Cardiac-Defibrillator: YES NO

Y. Thyroid Disease: YES NO

Z. Immune Suppression or Deficiency: YES NO

AA. Tuberculosis: YES NO

BB. Cancer/Chemo/Radiation Therapy: YES NO

CC. Artificial/Prosthetic Joint Replacement (knee or hip): YES NO Date: _____

DD. Drug Abuse (cocaine, methamphetamines, heroin, etc) 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 Medical History

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 Explained:

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 check 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.

Women Only
Are you pregnant? YES NO If Yes, Due Date: _____

Are you currently breastfeeding? YES NO

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

Candidate Initials Date Candidate Signature

(Added at end of exam)

AMERICAN SOCIETY OF ANESTHESIOLOGY (ASA) CLASSIFICATION CLASS _____

(ASA I: Normal healthy patient; ASA II: Patient with mild systemic disease; no functional limitation–eg, smoker with well-controlled hypertension; ASA III: Patient with severe systemic disease; definite functional impairment–eg, diabetes mellitus (DM) and angina pectoris with relatively stable disease, but requiring therapy)