Dental Hygiene 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 [ ][ ][ ][ ][ ]

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.

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. 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 3 OR ANY OTHER CONDITIONS NOT LISTED ABOVE

4. 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**
5. 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**
6. 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 →

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

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	**YES**	**NO**	________________
b.	Abnormal masses on palpation of the salivary glands or lymph nodes	**YES**	**NO**	________________
c.	Yellowing of oral mucosa	**YES**	**NO**	________________
d.	Bluish or white patches on oral mucosa	**YES**	**NO**	________________
e.	Red or pigmented areas on oral mucosa	**YES**	**NO**	________________
f.	Vesicles or bullae on oral mucosa	**YES**	**NO**	________________
g.	Oral ulcers	**YES**	**NO**	________________
h.	Abnormal oral masses	**YES**	**NO**	________________

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: __________

CANDIDATE SIGNATURE: ____
(Added at end of exam)