INSTRUCTIONS:
- **Use blue or black INK to complete this form**
- **Have patient complete this form PRIOR to the exam**
- **Bring this completed form with you to the exam**

CANDIDATE NUMBER

CRDTS PATIENT HEALTH HISTORY SCREENING FORM

Patient name:_____

Birthdate:_____**Weight:**_____ **Pre-exam Screening Blood Pressure** _____ /_____ *** Day of Exam Blood Pressure** _____ /_____

INSTRUCTIONS TO PATIENT: Please answer the following questions as completely and accurately as possible.
All information is CONFIDENTAL.

1. Physician's name:_____Physician's Phone:(_____)_____

2. Date of last physical examination:_____

3. Are you under the care of a physician at the present time, or have you been treated by a physician/PA in the last six months?

   If YES, please specify:_____ YES NO

4. Are you allergic or had any adverse reactions to any medicines, drugs, local anesthetics, or other substances? YES NO

   If YES, please identify: _____

5. Do you have a known allergy or sensitivity to Latex? YES NO

6. Are you receiving or have you ever received/taken INTRAVENOUS Bisphosphonates? YES NO
   i.e. Have you taken any of the following drugs INTRAVENOUSLY for the treatment of Osteoporosis or cancer? Clondronate (Bonefos®, Clasteon®, or Ostac®), Pamidronate (Aredia®), Zolendronic acid (Zometa® or Aclasta®), Neridromate (Nerixia®),or Reclast®. This list of IV Bisphosphonate medications should not be considered complete as new drugs are continually being developed.

7. Do you have or have you had any of the following diseases/conditions?

A. Cardiac/Organ Transplant	YES	NO	
B. Osteocraneonecrosis of the jaw	YES	NO	
C. Tuberculosis (active/currently)	YES	NO	
D. Heart Attack	YES	NO	If YES Date:_____
E. Heart Surgery (including stents)	YES	NO	If YES Date:_____
F. Stroke	YES	NO	If YES Date:_____
G. Chemotherapy	YES	NO	If YES Date:_____
H. Pregnant (currently pregnant)	YES	NO	If YES Due Date: _____
I. Artificial /Damaged Heart Valve(s)	YES	NO	
J. History of Infective Endocarditis	YES	NO	
K. Congenital Heart Conditions	YES	NO	
L. Joint Replacement	YES	NO	
M. Immune Suppression/HIV/AIDS	YES	NO	
N. Heart Condition (including pacemaker)	YES	NO	
O. Asthma/Lung/Breathing Disorder	YES	NO	
P. Bleeding Disorder	YES	NO	
Q. Cancer	YES	NO	
R. Diabetes	YES	NO	If YES Type: _____
S. Epilepsy/Seizures	YES	NO	
T. Hepatitis	YES	NO	If YES Type:_____
U. High Blood Pressure	YES	NO	
V. Kidney/Renal Disease	YES	NO	

W. Do you have any disease or condition not listed above that we should know about? YES NO

If YES, please specify:_____

_____

Please explain any YES answers here

Question # _____
Explanation:

_____

_____

_____

Question # _____
Explanation:

_____

_____

_____

Question # _____
Explanation:

_____

_____

_____

If more space is needed, please use the back of this form.

***Please list ALL medications/drugs, dose and time taken: prescription, over the counter, non-prescription, recreational, that you have taken in the last 24 hours:**

_____

_____

_____

_____

Any item on the medical history with a YES response may require a medical clearance letter if the explanation section indicates the possibility of a significant systemic condition that could adversely affect the patient's suitability to take part in the examination.

Securely attach any medical clearance letters to this form.

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:_____

(Parent or Guardian if patient is a minor)

DATE SIGNED:_____

If needed, additional information:

_____

_____

_____

_____

_____

****All items marked with an asterisk must be completed the DAY OF THE EXAMINATION***

