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

ONE OR TWO DIGIT CANDIDATE NUMBER

2027 CRDTS PATIENT HEALTH HISTORY SCREENING FORM

Patient name: _____

Birthdate: _____

Pre-exam Screening
Blood Pressure _____ /_____

*** Day of Exam @ Testing Site**
Blood Pressure _____ /_____

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

YES NO 1. Are you currently under the care of a physician/primary care provider or has a healthcare provider treated you in the last six months?
If YES, please specify: _____

YES NO 2. Are you allergic or had any adverse reactions to LATEX, any medicines, drugs, local anesthetics, or other substances?
If YES, please identify: _____

YES NO 3. Are you currently receiving INTRAVENOUS bisphosphonates for the treatment of osteoporosis or cancer?

Answer Below 4. Do you have or have you had any of the following diseases/conditions?

YES NO 4A. Cardiac/Organ Transplant
YES NO 4B. Tuberculosis (active/currently)
YES NO 4C. Stroke If YES Date: _____
YES NO 4D. Chemotherapy/Radiation Therapy If YES Date: _____
YES NO 4E. Heart Attack If YES Date: _____
YES NO 4F. Heart Surgery (including stents) If YES Date: _____
YES NO 4G. Artificial/Prosthetic/Damaged Heart Valve(s)
YES NO 4H. History of Infective Endocarditis
YES NO 4I. Heart Conditions (Congenital, Atrial Fibrillation)
YES NO 4J. Cardiac Medical Devices (including pacemaker, defibrillator, watchman)
YES NO 4K. Joint Replacement
YES NO 4L. Osteochemonecrosis of the Jaw
YES NO 4M. Pregnant If YES Due Date: _____
YES NO 4N. Asthma/Lung/Breathing Disorder/COPD
YES NO 4O. Bleeding Disorder
YES NO 4P. Cancer
YES NO 4Q. Diabetes If YES Type: _____
YES NO 4R. Epilepsy/Seizures
YES NO 4S. Liver Disease/Jaundice/Cirrhosis/Hepatitis if YES Type: _____
YES NO 4T. High Blood Pressure
YES NO 4U. Immune Suppression/HIV/AIDS
YES NO 4V. Kidney/Renal Disease
YES NO 4W. Mental Health Disorders
YES NO 4X. Substance Abuse Disorders
YES NO 4Y. Do you have any disease or condition not listed above?
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.

Any item on the health history with a YES response may require a medical clearance from a licensed primary care provider or dentist of record 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.

List all prescribed, over-the-counter, and recreational drugs taken within the last 48 hours:

IF NONE PLEASE MARK "X" HERE: _____

Name of Drug	Amount/Dose	Reason for Taking	Last Taken (Day/Time)

If needed, record additional information below:

_____

_____

_____

_____

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: _____

(Parent or Guardian if the patient is a minor)

I hereby attest to the fact that this Health History Screening Form was reviewed and updated on the day of the exam.
***Patient Initials _____ *Candidate Initials _____ *Today's Exam Date _____ /_____ /20___**

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