BP-A0787
JUN 10

DENTAL/MEDICAL HEALTH HISTORY

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

Language template provided in Spanish _____, **or** _____ .

1. Are you currently taking any medication? If so, what? _____	____ Yes	____ No
2. Are you allergic to or have you had a reaction to any medication or drug? If so, what? _____	____ Yes	____ No
3. Have you been under the care of a physician during the past two years? If so, what? _____	____ Yes	____ No
4. Have you been hospitalized in the past two years? If so, what? _____	____ Yes	____ No
5. Do you have or have you ever had a heart murmur or been treated for a heart condition?	____ Yes	____ No
6. Have you ever been treated for a tumor, growth, or cancer?	____ Yes	____ No
7. Have you ever had excessive or prolonged bleeding as result of a medical condition or medication (ex. Hemophilia or blood thinners)?	____ Yes	____ No
8. Do you have a latex allergy?	____ Yes	____ No
9. Do you currently use tobacco products?	____ Yes	____ No
10. WOMEN ONLY: Are you pregnant	____ Yes	____ No

Check any of the following that you have had:

- ____ **Congenital hear defects**
- ____ **Heart attack or heart problems**
- ____ **Stroke**
- ____ **Rheumatic fever**
- ____ **Mitral Valve Prolapse**
- ____ **Anemia (blood problems)**
- ____ **Thyroid problems**
- ____ **Chronic bronchitis**
- ____ **STD (syphilis, gonorrhea, herpes)**
- ____ **Angio edema**
- ____ **Arthritis**
- ____ **Artificial heart valve**
- ____ **Hepatitis (___ A ___ B ___ C)**
- ____ **Any type of transplant**
- ____ **Steroid treatment**
- ____ **Sickle Cell Anemia**
- ____ **Angina**
- ____ **High blood pressure**
- ____ **Heart pacemaker**
- ____ **Glucose - 6 - phosphate dehydrogenase deficiency**
- ____ **Epilepsy or seizures**
- ____ **Diabetes**
- ____ **AIDS or HIV infection**
- ____ **Emphysema**
- ____ **Tuberculosis (TB)**
- ____ **Psychiatric treatment**
- ____ **Artificial joint**
- ____ **Radiation therapy**
- ____ **Asthma**

Do you have any disease, condition, or problem not listed? _____

Check any of the following that you have had or applies to you:

- ____ **Sensitive teeth**
- ____ **Bleeding gums**
- ____ **Food impaction**
- ____ **Pain around ear**
- ____ **Tooth ache**
- ____ **Wear partial dentures**
- ____ **unusual sounds while eating**
- ____ **Snoring**
- ____ **Blisters on lips or mouth**
- ____ **Clenching or grinding**
- ____ **Tooth ache**
- ____ **Swelling or lumps in mouth/throat**
- ____ **Burning tongue**
- ____ **Bad breath**
- ____ **Decayed teeth**
- ____ **Loose teeth**
- ____ **Wear dentures**

Printed Name: _____	Signature:
Reg. No. : _____	Institution _____
Date: _____	Updated: _____