

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, why?	YES	NO
4. Have you been hospitalized in the past two years? If so, why?	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 a 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 heart defects          | Arthritis                                      | Epilepsy or seizures  |
| Heart attack or heart problems    | Artificial heart valve                         | Diabetes              |
| Stroke                            | Hepatitis (   A   B   C )                      | AIDS or HIV infection |
| Rheumatic fever                   | Any type of transplant                         | Emphysema             |
| Mitral Valve Prolapse             | Steroid treatment                              | Tuberculosis (TB)     |
| Anemia (blood problems)           | Sickle Cell Anemia                             | Psychiatric treatment |
| Thyroid problems                  | Angina   | Artificial joint      |
| Chronic bronchitis                | High blood pressure                            | Radiation therapy     |
| STD (syphilis, gonorrhea, herpes) | Heart pacemaker                                | Asthma                |
| Angio edema                       | Glucose - 6-phosphate dehydrogenase deficiency |                       |

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

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