

## Health Declaration Form

**Volunteer's Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Answer all questions by circling Yes (Y) or No (N)**

**All responses are kept confidential**

1. Are you in good health? .....Y N
2. Has there been any change in your general health in the past year? .....Y N
3. Date of last physical exam \_\_\_\_\_
4. Are you now under a physician's care for a particular problem? .....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N  
\_\_\_\_\_

- F. Tranquilizers? .....Y N
- G. Insulin or Oral Anti-Diabetic drugs? .....Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Anti-depressants, mood stabilizers, anti-psychotics Y N
- J. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_  
\_\_\_\_\_

**7. DO YOU HAVE OR HAVE YOU EVER HAD:**

- A. Rheumatic Fever or Rheumatic Heart Disease? .....Y N
- B. Congenital Heart Disease? .....Y N
- III. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) .....Y N
- IV. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? .....Y N
- V. Seizures, Convulsions, Epilepsy, Fainting or Dizziness.....Y N
- VI. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? .....Y N
- G. Liver Disease (Jaundice, Hepatitis)?.....Y N
- H. Kidney Disease? .....Y N
- I. Diabetes?.....Y N
- J. Thyroid Disease (Goiter)?.....Y N
- K. Arthritis?.....Y N
- L. Stomach Ulcers or Colitis?.....Y N
- M. Glaucoma?.....Y N

XIV. Implants placed in your body (Heart Valve, Pacemaker, Hip, Knee)? .....Y N

O. Radiation (X-ray) treatment for Cancer? .....Y N

P. Sinus or Nasal problems?.....Y N

XVII. ....  
Any disease, drug or transplant operation that has depressed your immune system? .....Y N

XVIII. Back Pain, Difficulty lifting heavy loads?.....Y N

**8. ARE YOU CURRENTLY USING ANY OF THE FOLLOWING:**

- A. Antibiotics?.....Y N
- B. Anticoagulants (Blood Thinners)? .....Y N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen?.....Y N
- D. High Blood Pressure medications? .....Y N
- E. Steroids (Cortisone, etc.)? .....Y N

**9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

- A. Local Anesthesia (Novocain, etc.)? .....Y N
- B. Penicillin or other antibiotics? .....Y N
- C. Sedatives, Barbiturates?.....Y N
- D. Aspirin or Ibuprofen?.....Y N
- E. Codeine or other pain killers? .....Y N
- F. Latex or Rubber Products? .....Y N
- G. Other allergies or reactions? Please, list.....Y N  
\_\_\_\_\_

10. Do you smoke or chew Tobacco? .....Y N  
How much per day? \_\_\_\_\_

11. Is there any past history of Alcohol or Chemical Dependency Disorder that may affect the work you will be assigned?.....Y N

12. Have you had any serious problems associated with any previous dental treatment? .....Y N

13. Bearing in mind the various conditions imposed by a foreign work program (lengthy absence from home, adjustment to a foreign culture, new social contacts) do you believe that you are emotionally stable enough to participate? .....Y N

14. Do you have any other disease, condition or problem not listed above that you think we should know about? .....Y N  
Please elaborate:.....  
\_\_\_\_\_

15. Have you been diagnosed and/or treated for emotional problems (depression, anxiety, etc) .....Y N  
\_\_\_\_\_

16. Do you wish to talk to one of our doctors privately about anything? .....Y N

**I understand the importance of a truthful Health History to assist MOLSA in providing a safe environment for volunteers and patients. I have had the opportunity to discuss my Health History with my doctor.**

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Person Completing Health History

\_\_\_\_\_

Physician's signature