

**Stony Brook Family & Preventive Medicine, UFPC
Occupational & Environmental Medicine
181 N. Belle Mead Road, Suite #2
East Setauket, New York 11733
Fax: (631) 444-6250**

Dental School Student Annual Assessment Form

Name: _____

Address: _____

E-mail Address: _____

Date of Birth: ____/____/____

Best Phone: _____

Employee Complete Section I – II / Healthcare Provider Complete Section III - V

I. UPDATE MEDICAL HISTORY

Class Year: Class of _____ (please enter anticipated graduation year)

1) Did you have any leaves of absence in the past 12 months? NO YES

2) Have you had any needlesticks or other injuries over the past 12 months? NO YES: Please explain below:

3) Please list any chronic health issues, major illnesses, hospitalizations or operations over the past 12 months:

4) List ALL current medications: _____

5) Have you had a vaccination within the past 12 months? NO YES: list vaccine(s) below and attach documentation

6) Allergies: _____ Latex Allergy? NO YES: describe reaction: _____

7) Women only: Are you currently or have you been pregnant in the past year? NO YES

8) Who is your private physician? _____

II. STUDENT ATTESTATION

I certify that I am free from a health impairment, which might interfere with my education/training program including habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter behavior.

Student Signature

Date

