Administrative Information

0a. Completion Date: [ ] [ ] [ ] 0b. Staff ID: [ ] [ ] [ ]

Instructions: This safety screening form should be administered during the appointment reminder call and again prior to the exam. Positive responses to Questions 1 – 5 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.

1. Are you on any medication for diabetes or any other medication prescribed by a physician that needs to be taken on a schedule?
   - Yes [ ] \( \rightarrow \) Report on Exam Itinerary Checklist
   - No [ ] \( \rightarrow \) Go to Item 2

1a. If yes, details: ________________________________________________________________

2. Do you need any other medical support that we should be aware of?
   - Yes [ ] \( \rightarrow \) Report on Exam Itinerary Checklist
   - No [ ] \( \rightarrow \) Go to Item 3

2a. If yes, details: ________________________________________________________________

3. Do you have either a heart pacemaker or defibrillator (AICD)?
   - Yes [ ] \( \rightarrow \) Report on Exam Itinerary Checklist
   - No [ ]

4. Do you have a history of skin allergic reaction to adhesive tape?
   - Yes [ ] \( \rightarrow \) Report on Exam Itinerary Checklist
   - No [ ]

5. Do you have an implanted medical device other than a pacemaker or defibrillator (AICD)?
   - Yes [ ] \( \rightarrow \) Report on Exam Itinerary Checklist
   - No [ ]

5a. If yes, please specify the type of device(s): ________________________________________________