

BMWDA - 2

Patient Name:

Birth Date:

Date Created:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel, Aredia, Zometa or any other medications containing bisphosphonates? Yes No If yes

Are you taking blood thinners - coumadin, plavix, eloquis, etc.? Yes No If yes

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No If yes

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin or other antibiotics Codeine or other narcotics Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No	Anemia <input type="radio"/> Yes <input type="radio"/> No
Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Heart Disease <input type="radio"/> Yes <input type="radio"/> No	Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No
High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No
Shingles <input type="radio"/> Yes <input type="radio"/> No	Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No	Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No	Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No
Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No
Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No	Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No
Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No
Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No	Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No	Arteriosclerosis <input type="radio"/> Yes <input type="radio"/> No	Congestive Heart Failure <input type="radio"/> Yes <input type="radio"/> No
Damaged Heart Valves <input type="radio"/> Yes <input type="radio"/> No	Abnormal Bleeding <input type="radio"/> Yes <input type="radio"/> No	Autoimmune Disease <input type="radio"/> Yes <input type="radio"/> No	Rheumatoid Arthritis <input type="radio"/> Yes <input type="radio"/> No
Systemic lupus erythematosus <input type="radio"/> Yes <input type="radio"/> No	Chronic Pain <input type="radio"/> Yes <input type="radio"/> No	GI Reflux/persistent heartburn <input type="radio"/> Yes <input type="radio"/> No	Neurological disorders <input type="radio"/> Yes <input type="radio"/> No
Sleep disorder <input type="radio"/> Yes <input type="radio"/> No	Mental health disorders <input type="radio"/> Yes <input type="radio"/> No	Recurrent infections <input type="radio"/> Yes <input type="radio"/> No	Persistent swollen glands in neck <input type="radio"/> Yes <input type="radio"/> No
Severe headaches/migraines <input type="radio"/> Yes <input type="radio"/> No	Excessive urination <input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Signature of Patient, Parent or Guardian:

X

Date: _____