

<b>Original Date:</b>	<b>Dr. Signature:</b>
<b>Revision Date &amp; Comments:</b>	

## *Delaney Family Dental Health history questionnaire*

**All questions contained in this questionnaire are strictly confidential. Please fill form completely.**

<b>Name</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

### PERSONAL HEALTH HISTORY

<b>Childhood illness:</b> <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
<b>Allergies to medications or latex</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>if yes list the them below</b>		

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Check if you have, or have had any diagnosis in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Liver problems	<input type="checkbox"/> AIDS
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Fainting
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Excessive Bleeding

### WOMEN ONLY

Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers</b>		

### HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	# Of cups/cans per day?
<b>Alcohol</b>	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
<b>Drugs</b>	Do you currently use recreational or street drugs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever taken street drugs with a needle?				<input type="checkbox"/> Yes <input type="checkbox"/> No