HAYFIELD
DENTAL CARE

DENTAL HEALTH RECORD

Welcome! So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Name ______________________ Date of Birth __________ ☐ Male ☐ Female

______________________ Weight __________ Home Phone No. __________

Height __________ Work Phone No. __________

MEDICAL HISTORY

Name and address of physician ______________________

When was your last physical examination? ______________________

Are you now under the care of a physician? Yes ☐ No ☐

If yes, for what reason? ______________________

Are you presently taking any medications/drugs/pills? Yes ☐ No ☐

Please list: ______________________

Are you allergic (or have an adverse reaction) to:

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ None ☐ Other __________

Are you sensitive or allergic to latex? Have you experienced itching, rash or wheezing after using latex gloves or handling a balloon? Have you had any unusual or unexplained reactions during a surgical procedure? No ☐ Yes ☐ Explain __________

(Women) Are you pregnant? Yes ☐ No ☐ If yes, how long? __________

Do you have, or have you ever had:

Condition		
Heart (Trouble, Disease, Surgery)	Yes	No
Heart murmur	Yes	No
Heart pacemaker	Yes	No
Rheumatic fever or Rheumatic heart disease	Yes	No
Congenital heart defects	Yes	No
Artificial heart valve	Yes	No
Mitral valve prolapse	Yes	No
Abnormal blood pressure	Yes	No
Ulcers	Yes	No
Tuberculosis or lung disease	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Anemia	Yes	No
Thyroid problems	Yes	No
Recreational Drug use	Yes	No
Chemical dependency	Yes	No
Kidney problems	Yes	No
Liver disease	Yes	No
Jaundice	Yes	No
Hepatitis - Type: A B C	Yes	No
Arthritis/Rheumatism	Yes	No
Cortisone medicine	Yes	No
Excessive or prolonged bleeding	Yes	No
Blood Transfusions	Yes	No
Hemophilia	Yes	No
Sickle Cell Disease	Yes	No
Fainting spells	Yes	No
Asthma or hay fever	Yes	No
Emphysema	Yes	No
Sinus trouble	Yes	No
Cancer/Tumors/Lesions	Yes	No
Chemotherapy/radiation	Yes	No
Stroke	Yes	No
Glaucoma	Yes	No
Psychiatric care/History of Eating Disorder	Yes	No
Neurological disorders	Yes	No
Prosthetic implant/artificial joint	Yes	No
Venereal disease	Yes	No
HIV positive/AIDS/ARC	Yes	No
Hearing impaired	Yes	No

Have you had any other serious illness, hospitalization or accident? Yes No

B.P. __________

If yes, please explain ______________________

History Review

Recorded by __________ D.D.S. Signature __________ Date __________

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient signature ______________________ Date __________

(PARENT/GUARDIAN IF A MINOR)

Patient __________ Acct # __________ Chart # __________

DENTAL HISTORY

What is the reason for your visit today?____

Previous Dentist's Name________________________Address______________________________
Date of: Last Visit _____________ Last Hygiene Visit____________________Last X-Rays__________
Why did you leave that practice?____
Were you referred to a specific dentist at this office or would you like to request a specific dentist for your examination? No Yes, Dr.____
How often do you have dental examinations?____
How often do you brush your teeth?______________How often do you floss?__________________
What other aids do you use? (Interplak, toothpick, etc.)____________________________________
Do you have any dental problems now? Yes No
If yes, please describe ____
____

Do you feel anxiety about having dental treatment?..Yes or No
Have you ever had an upsetting dental experience?..Yes or No
If yes, please describe____
____

Are any of your teeth sensitive to:

Hot or Cold?	Yes or No
Sweets?	Yes or No
Biting or pressure?	Yes or No
Have you ever noticed any mouth odors or bad taste?	Yes or No
Do your gums bleed or hurt?	Yes or No
Have you noticed any loose teeth or change in your bite?	Yes or No
Does food tend to become caught between your teeth?	Yes or No

Do You:

Clench or grind your teeth?	Yes or No
Bite your lips or cheeks regularly?	Yes or No
Mouth breath while asleep or awake?	Yes or No
Snore?	Yes or No
Use Tobacco: Cigarettes, Pipe or Chew?	Yes or No

Have you ever experienced:

Clicking or popping of the jaw?	Yes or No
Difficulty opening or closing the mouth?	Yes or No

Have you ever had:

Orthodontic treatment?	Yes or No
Oral Surgery?	Yes or No
Fixed Bridge?	Yes or No
Removable Partial?	Yes or No
Complete Denture?	Yes or No
Implant?	Yes or No
Periodontal Treatment?	Yes or No
Gum Surgery?	Yes or No
A serious injury to the mouth or head?	Yes or No

If so, please describe. Include cause_____________________________________
____
____

Are you dissatisfied with the appearance of your teeth? Yes or No

Are your teeth discolored?	Yes or No
Are your teeth crooked?	Yes or No
Would you like to change the appearance of your teeth?	Yes or No

Is there anything else about having dental treatment that you would like us to know, please describe.___________________________________
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