MURPHY DENTAL GROUP
DENTAL & MEDICAL HISTORY

PLEASE COMPLETE INFORMATION – THANK YOU

DATE OF BIRTH:_____

PATIENT FIRST NAME:_____ PATIENT LAST NAME:_____

DENTAL HISTORY

Reason for today's visit:_____ Date of last dental visit_____

Former Dentist:_____ Date of last dental x-rays_____

Please check if you have/had:	YES	NO		YES	NO
Bad breath	___	___	Head, neck, jaw pain, aches	___	___
Blisters on lips or mouth	___	___	Lip or cheek biting	___	___
Burning sensation on tongue	___	___	Loose teeth or broken fillings	___	___
Chew on one side of mouth	___	___	Mouth breathing	___	___
Cigarette, pipe, or cigar smoking	___	___	Orthodontic treatment	___	___
Smokeless tobacco/Vape	___	___	Dry Mouth	___	___
Periodontal Treatment	___	___	Food collection between teeth	___	___
Sensitivity to pressure/irritants			Clench or grind teeth	___	___
(hot, cold sweets)	___	___	Growths or sore spots in mouth	___	___
Gum swollen tender or bleeding	___	___	How often do you floss?_____		
How often do you brush?_____			Do you like your smile?_____		

Have you ever had an allergic reaction to Novocain, local or general anesthetics? ___ ___

Have you ever had trouble from previous dental care?_____ If yes, please explain_____

_____

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Physician's address_____ Blood pressure_____

Have you ever had serious illness or operations_____ If yes, please describe_____

_____

Have you ever had a blood transfusion?_____ If yes, give approximate dates_____

(Woman) Are you pregnant? Y / N (circle) Due date:_____ Nursing Y / N (circle)

Taking birth control pills? Y / N (circle)

Please check if you have/had:	YES	NO		YES	NO
Allergies, hay fever, sinusitis	___	___	Headaches	___	___
Anemia	___	___	Heart murmur	___	___
Arthritis Rheumatism	___	___	Heart problems	___	___
Artificial heart valves	___	___	Hepatitis type _____	___	___
Artificial joints	___	___	Herpes	___	___
Asthma	___	___	High blood pressure	___	___

MEDICAL HISTORY

Please check if you have/had:	YES	NO
Any immune deficiency	___	___
Jaundice	___	___
Bleeding abnormally with operations or surgery		
Low blood pressure	___	___
Mitral valve prolapse	___	___
Osteoporosis	___	___
Osteopenia	___	___
Pacemaker	___	___
Radiation treatments	___	___
Respiratory disease	___	___
Rheumatic fever	___	___
Scarlet fever	___	___
Shortness of breath	___	___
Sinus trouble	___	___
Sickle cell anemia	___	___
Skin rash	___	___
Stroke	___	___
Thyroid Problems	___	___
Tuberculosis	___	___
Ulcer	___	___
Weight loss, unexplained	___	___
Do you consume alcoholic beverages?		
Are you allergic/sensitive to Latex?		
Allergic to Penicillin, Aspirin or other drugs?		

	YES	NO
Have you used steroids	___	___
Kidney disease	___	___
	___	___
Blood disease, clotting disorder	___	___
Cancer	___	___
Chemical dependency	___	___
Chemotherapy	___	___
Circulatory problems	___	___
Cortisone treatments	___	___
Persistent cough	___	___
Diabetes	___	___
Emphysema	___	___
Epilepsy	___	___
Fainting	___	___
Glaucoma	___	___
Slow healing wounds	___	___
Swelling of feet or ankles	___	___
Tonsillitis	___	___
Tumor or growth head or neck	___	___
Venereal disease	___	___
Do you wear contact lenses	___	___
	___	___
	___	___
	___	___

If yes, please specify_____

List any medications you are currently taking:_____

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature_____ Date:_____

Reviewed by:_____ Date:_____