❑ **YOGI DENTAL CENTER** ❑ **SMILECARE OF DENVILLE**

Comprehensive Medical History Form

LAST NAME _____ **FIRST NAME** _____ **DATE OF EXAM** _____

ADDRESS _____ **CHIEF COMPLAINT** _____

BIRTH DATE _____ **HOME PHONE** _____ **BUSINESS PHONE** _____

	YES	NO
1. Are you in good health?	❑	❑
2. **Are you under the care of a physician?**	❑	❑
3. **Have you had a recent illness or operation?**	❑	❑
4. **Are you taking any medications? If yes, please list:**	❑	❑
5. **Are you allergic to any foods or drugs? If yes, please list:**	❑	❑
6. **Are you allergic to penicillin, aspirin, or codeine?**	❑	❑
7. **Are you allergic to any local or general anesthesia?**	❑	❑
8. **Are you pregnant? If so, what month?**	❑	❑

HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING

For the following questions, check Yes or No. Your answers are only for our records and are strictly confidential.

	YES	NO		YES	NO		YES	NO
Heart Disease	❑	❑	**Tuberculosis**	❑	❑	**Excessive Bleeding from Cut or Fracture**	❑	❑
Heart Murmur	❑	❑	**Sinus Problems**	❑	❑	**Problems with Local Anesthesia**	❑	❑
Rheumatic Fever	❑	❑	**Thyroid Problems**	❑	❑	**Diabetes**	❑	❑
Angina	❑	❑	**Kidney Problems**	❑	❑	**Seizures, Epilepsy**	❑	❑
Irregular Heart Beat	❑	❑	**Liver Disease**	❑	❑	**Ulcers**	❑	❑
High or Low Blood Pressure	❑	❑	**Hepatitis**	❑	❑	**Venereal Disease**	❑	❑
Difficulty in Breathing	❑	❑	**Immune System Deficiency**	❑	❑	**Tumors or Growths**	❑	❑
Asthma	❑	❑	**Blood Disease**	❑	❑	**Radiation Treatments**	❑	❑
Bronchitis	❑	❑	**Bleeding Problems**	❑	❑	**Stroke**	❑	❑
Hay Fever	❑	❑	**Anemia**	❑	❑			

Reviewed by: _____ **Patient Signature** _____

History Taken by: _____ **Date** _____