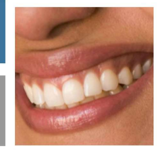
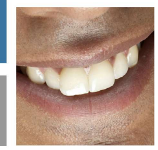
Tri County Dental Care

208 North Washington Ave
Dunellen, NJ 08812

(732)968-2727

tricounty208@gmail.com
www.bestsmilesnj.com





Medical History

Patient Name:* ____________ * ____________ ____ ____________

Last | First | MI | Preferred Name

1. Has there been any changes in your general health within the past year

◯ Yes ◯ No

2. My last physical examination was on:

____

3. Are you under the care of a physician

◯ Yes ◯ No

If yes, What is the condition being treated:

____

4. The name and address of my physician is:

____

5. Have you had any serious illness within the past 5 years:

◯ Yes ◯ No

If so, what was the illness:

____

6.Have you been hospitalized or had an operation within the past 5 years:

◯ Yes ◯ No

If so, what was the problem

____

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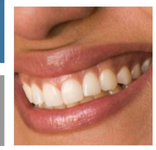
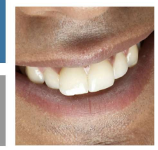



Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

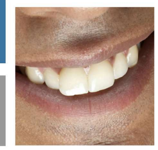
- ☐ *Pre-Medicate
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Antidepressants
- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Bipolar
- ☐ BloodDisorder Anemia
- ☐ Congential Heart
- ☐ Diabetes
- ☐ DIgestive Problems
- ☐ Epilepsy/Seizures
- ☐ Fainting spells
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholestrol
- ☐ High/Low BP
- ☐ HIV / AIDS
- ☐ Hives/Skin Rash
- ☐ ImmuneSystemDisorder
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ MitralValveProlapse
- ☐ Pacemaker
- ☐ Persistant Cough
- ☐ Psychiatric Disorder
- ☐ Rheumatic Fever
- ☐ STD / HPV
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ xOther Explain Below

12. Are you taking any of following:

- ☐ Antibiotics or Sulfa drugs
- ☐ Anticoagulants(Blood thinner)
- ☐ Cortisone(steriods)
- ☐ Tranquilizers
- ☐ Anti histamine
- ☐ Aspirin
- ☐ Insulin, tolbutamide or similar drug for diabetes
- ☐ Digitalis or drugs for heart troubles
- ☐ Nitroglycerin
- ☐ Other

If yes to any of the above, state drugname, dosage and frequency





3. Are you allergic or have any reacted adversely to:

- ☐ Local anesthetics
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codine or other narcotics
- ☐ Penicillin or other antibiotics
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Iodine
- ☐ Other

4. Do you use any tobacco products

◯ Yes ◯ No

If yes, how much per day and what

5. Do you use any alcohol products:

◯ Yes ◯ No

if yes, how much per day/ week./ onth and what

6. Do you use any caffeinated products (Coffee, tea. chocolate etc)

◯ Yes ◯ No

If yes, how much per day and what

8. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation:

◯ Yes ◯ No

9. Are you wearing contact lenses:

◯ Yes ◯ No

10. Are you experiencing stress or pressure in your work or at home

◯ Yes ◯ No

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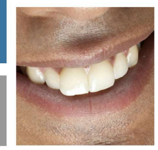

WOMEN

1. Are you pregnant

◯ Yes ◯ No

2. Do you have PMS or problems associated with your menstrual period

◯ Yes ◯ No

3. Are you taking birth control or hormone therapy

◯ Yes ◯ No

Pharmacy Name

Pharmacy Phone Number

* ☐ To the best of my knowledge, all of the preceding answers are true and correct. If i ever have any changes in my health or change in my medication, will inform the dentist atte next appointment.

Response Date:

Patient Signature X ______________________