

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
State Surgeon General and Secretary

Vision: To be the Healthiest State in the Nation

Florida Department of Health in Nassau County Dental Health History

Patient's Name: _____
Last
First
M

DOB: _____ Social Security Number: _____

1. Do you (PATIENT) have or have you (PATIENT) had any of the following:

- | | | | | | |
|--------------------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Rheumatic Fever or Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Trouble or Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (TB) or Persistent Cough | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High or Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes or Excessive Thirst | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting or Dizzy Spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems or Excessive Urination | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia or Blood Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Problems or Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Excessive Bleeding or Bruise Easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS/ARC/HIV positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Transfusions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies or Skin Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Trimester 1 2 3 | | |
| Thyroid Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Painful or Swollen Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other _____ | | |

2. Are you (PATIENT) currently under the care of a physician (doctor)? Yes No
 If yes, list name of doctor. _____

3. Have you (PATIENT) been hospitalized in the last 2 years? Yes No
 If yes, describe _____

4. Are you (PATIENT) currently taking any medications, pills or drugs? Yes No
 If yes, list. _____

5. Are you (PATIENT) allergic to or have you ever experienced any ill effect from a local Anesthetic (Novocain), Penicillin, or any drugs/pills? (EX: rash, itching, or fainting). Yes No
 If yes, describe _____

6. Have you (PATIENT) ever experienced any unfavorable reaction from previous Dental treatment? Yes No
 If yes, describe _____

7. Are you (PATIENT) currently having any dental pain or problem? Yes No
 If yes, describe _____

I certify that I have read and understand the above questions and have answered the questions to the best of my knowledge. I have asked for an explanation of any terms (words) that I did not know (if any), and my questions have been answered to my satisfaction. I will not hold my dentist, or any of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I also understand that before treatment is provided, I have the right to have the benefits, alternatives, and significant risk factors associated with this treatment explained to my satisfaction.

Patient/Parent or Guardian of Patient Signature _____ Date _____
 (If patient is a child, parent or legal guardian must sign) Relationship to Patient _____

Comments by Dentist: _____

Signature of Dentist _____ Date _____