

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
Interim State Surgeon General

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	Veneral 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		
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emotional Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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 _____