KIMBERLY DENTAL MEDICAL HISTORY

Do you have or have you had any of the following?

	YES	NO
Heart Problems	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart Murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Pacemaker	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Allergy Problems	☐	☐
Hay Fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Joint replacement *(e.g.,total hip, pin, or implants)*	☐	☐
Kidney Problems	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by Physician	☐	☐
Cancer/Tumor	☐	☐

	YES	NO
Diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you smoke? If so, how much?	☐	☐
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Epilepsy or other neurological diseases	☐	☐
History of Alcohol or drug abuse	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe:	☐	☐

WOMEN	YES	NO
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? If so, expected delivery date:	☐	☐
Are you nursing?	☐	☐

ALLERGIES	YES	NO
Do you have any allergies to metals, latex or medications If yes, please list below.	☐	☐
Are you taking any medications or substances If yes, please list below.	☐	☐

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENTS'S/GUARDIAN SIGNATURE _____ DATE _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____

Signature _____ Date: _____