KIMBERLY DENTAL MEDICAL HISTORY

Do you or have you had any of the following?

- ○ Allergies
  List: _____
  _____
- ○ Abnormal Bleeding
- ○ AIDS
- ○ Anemia
- ○ Asthma
- ○ Birth Control
- ○ Blood Disease
- ○ Blood Thinner
- ○ Bone Density Medication
- ○ Bruxism Appliance
- ○ Cancer
  Type: _____
  Date: _____
- ○ Diabetes
  Type: _____
- ○ Easy Bruising
- ○ Heart Attack
  Date: _____
- ○ Heart Condition
- ○ Heart Murmur
- ○ Heart Surgery
  Date: _____
- ○ Heart Trouble
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV
- ○ Joint Replacement
  Type: _____
  Date: _____
- ○ Kidney Problem
- ○ Kidney Transplant
  Date: _____
- ○ Low Blood Pressure
- ○ Malignancies
- ○ Medications:
  List:
  _____
  _____
  _____
  _____
  _____
  _____
  _____
- ○ Mitral Valve Prolapse
- ○ Nursing
- ○ Pace Maker
- ○ Pregnant
- ○ Premedication Required
  Name: _____
- ○ Prolonged Bleeding
- ○ Radiation Treatment
- ○ Sjogren's
- ○ Stroke
  Date: _____
- ○ Tuberculosis
- ○ Valve Replaced

Do you have any disease(s), condition(s), or problem(s) not listed previously that you feel we should discuss?

_____
_____
_____
_____
_____
_____

Physician:

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Signature: Date: