James D. Dickinson, D.D.S., Inc.

11777 Bernardo Plaza Ct., Suite 102
San Diego, CA 92128
(858) 487-7766

Patient's Name ____
Last First Initial Date of Birth

COMMENTS

		YES	NO
1.	Physicians Name______________________		
	Address______________________		
	Telephone______________________		
2.	Are you under a physician's care?..	☐	☐
	Since when______________________		
	Why______________________		
3.	When was your last complete physical exam? (Date) ______________		
4.	Are you taking any medications or substances?..................................	☐	☐
5.	Do you routinely take health related substances? (Vitamins, herbal supplements, natural products)...	☐	☐
6.	Are you allergic to any medications or substances? If so, please list ______________________	☐	☐
7.	Do you have any other allergies or hives?...	☐	☐
8.	Do you have any problems with penicillin, antibiotics, anesthetics or other medications?..	☐	☐
9.	Are you sensitive to any metals or latex?..	☐	☐
10.	Are you pregnant or suspect you may be pregnant?...........................	☐	☐
11.	Do you use any birth control medications?...	☐	☐
12.	Have you ever been treated for or been told you might have heart disease?...	☐	☐
13.	Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapsed?...	☐	☐
14.	Have you ever had a rheumatic fever?..	☐	☐
15.	Are you aware of any heart murmurs?...	☐	☐
16.	Do you have high or low blood pressure?	☐	☐
17.	Have you ever had serious illness or major surgery?...........................	☐	☐
	If so, explain______________________		
18.	Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition?..	☐	☐
19.	Do you have inflammatory diseases, such as arthritis or rheumatism?	☐	☐
20.	Do you have any artificial joints/prosthesis?.......................................	☐	☐

Medical History

James D. Dickinson, D.D.S., Inc.

11777 Bernardo Plaza Ct., Suite 102
San Diego, CA 92128
(858) 487-7766

Patient's Name ____

Last First Initial Date of Birth

	YES	NO	COMMENTS
21. Do you have any blood disorders, such as anemia, leukemia, etc?.......	☐	☐	
22. Have you ever bled excessively after being cut or injured?.................	☐	☐	
23. Do you have any stomach problems?...	☐	☐	
24. Do you have any kidney problems?..	☐	☐	
25. Do you have any liver problems?..	☐	☐	
26. Are you diabetic?..	☐	☐	
27. Do you have fainting or dizzy spells?...	☐	☐	
28. Do you have asthma?...	☐	☐	
29. Do you have epilepsy or seizure disorders?..	☐	☐	
30. Do you or have you had venereal diseases?.......................................	☐	☐	
31. Have you tested HIV positive?...	☐	☐	
32. Do you have AIDS?..	☐	☐	
33. Have you had or do you test positive for hepatitis?............................	☐	☐	
34. Do you or have you had T.B.?...	☐	☐	
35. Do you smoke, chew, use snuff or any other forms of tobacco?..........	☐	☐	
36. Do you regularly consume more than one or two alcoholic beverages a day?...	☐	☐	
37. Do you habitually use controlled substances?....................................	☐	☐	
38. Have you had psychiatric treatment?..	☐	☐	
39. Have you taken any prescriptions drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products?...	☐	☐	
40. Do you have any disease condition, or problem not listed? If so, explain. ________________________________			
41. Is there anything else we should know about your health that we have not covered in this form?________________________			
42. Would you like to speak to the doctor privately about any problem?..	☐	☐	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GAURDIANS SIGNATURE________________________ Date________________

DENTIST'S SIGNATURE________________________ Date________________

Medical History