

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

**Has your address or phone number changed since your last visit? yes no

If so, please update below:

Address: _____ Phone: _____

Physician's Name: _____ Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (phentermine) Podimin (fenfluramine), and Redux (dexfenfluramine) yes no

Have you had any serious illness/operation? yes no If yes, describe: _____

Have you had a blood transfusion? yes no If yes, when? _____

(Women) Are you pregnant yes no Nursing? yes no Taking birth control? yes no

Check if you currently have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Cough - Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | |

**Are you currently taking a blood thinner? yes no If so, which one? _____

**Have you been diagnosed with Osteoporosis? yes no If so, are you currently receiving treatment? yes no

List medications you are currently taking and the correlating diagnosis:

Allergies:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

Signature

Date