Medical History

Patient's Name _____ Date of Birth _____

CIRCLE THE APPROPRIATE ANSWER, IF UNSURE, PLEASE WRITE "Don't Know" ON THE LINE PROVIDED
IF QUESTIONS ASKS "please list", PLEASE LIST ON BACK OF THIS PAGE

1. Please write down pharmacy, so we may call in prescriptions, if needed. If none write N/A.
   Name & Location: _____
   Phone Number: _____
2. Physicians Name _____
   Location_____

3. Are you under a physician's care? .....Yes No
   Since when _____ Why? _____
4. When was your last complete Physical exam? _____
5. Are you taking any medications or substances? (please list).....Yes No
6. Are you allergic to any medications or substances? (please list) .....Yes No
7. Do you have any other allergies? .....Yes No
8. Are you sensitive to any metals or latex? .....Yes No
9. Are you pregnant or suspect you may be? .....Yes No
10. Do you use any birth control medications? .....Yes No
11. Have you ever been treated for or been told you might have heart disease? .....Yes No
12. Do you have a pacemaker or an artificial heart valve implant? .....YesNo
13. Have you ever had rheumatic fever? .....Yes No
14. Are you aware of any heart murmurs? .....YesNo
15. Do you have high or low blood pressure? (please circle) .....YesNo
16. Have you had any serious or major surgery? .....YesNo
    If so, explain _____
17. Have you ever had radiation treatment, chemo treatment for tumor,
    Growth or other condition? .....Yes No
18. Do you have arthritis or other inflammatory disease? .....Yes No
19. Do you have artificial joints/prosthesis? .....Yes No
20. Do you have any blood disorders, such as anemia, leukemia, etc.? .....Yes No
21. Have you ever bled excessively after being cut or injured? .....Yes No
22. Do you have stomach problems? .....Yes No
23. Do you have kidney problems? .....YesNo
24. Do you have liver problems? .....Yes No
25. Are you diabetic? .....Yes No
26. Do you have fainting or dizzy spells? .....Yes No
27. Do you have asthma? .....Yes No
28. Do you have epilepsy or seizure disorders? .....Yes No
29. Do you or have you had a venereal disease? .....Yes No
30. Have you tested HIV positive? .....Yes No
31. Do you have AIDS? .....YesNo
32. Have you had or do you test positive for Hepatitis? .....YesNo
33. Do you or have you had T.B.? .....Yes No
34. Do you smoke, chew, use snuff or any other forms of tobacco? .....Yes No
35. Do you consume alcoholic beverages? .....Yes No
36. Do you habitually use controlled substances? .....Yes No
37. Have you had psychiatric treatment? .....Yes No
38. Have you taken any prescription drugs fenfluramine, fenfluramine w/phentermine (fen-phen),
    dexfenfluramine (redux), or other weight loss products? .....Yes No
39. Do you have any disease, condition or problem not listed? If so explain _____
    _____
40. Is there anything else we should know about your health that we did not cover in this form? .....Yes No
41. Would you like to speak privately to the doctor about any concerns? .....Yes No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN
SIGNATURE_____DATE_____