



MEDICAL HISTORY AND HEALTH INFORMATION

*These questions are for your benefit and assure that treatment/surgery will take into consideration your past and present health status

Are you in good health?..... Yes No

Have you ever had any extensive bleeding which required special treatment?..... Yes No

Are you under the care of a physician at this time?..... Yes No

If so, what is the condition being treated? _____

Do you use or have you ever used recreational drugs?..... Yes No

Do you wear a cardiac pace maker?..... Yes No

Are you on a special diet?..... Yes No

Do you currently smoke?..... Yes No

If not currently, when did you stop? _____

Do you consume alcohol? Yes No

Daily _____ Moderately _____ Never _____

Do you exercise? Yes No

Daily _____ Moderately _____ Never _____

Have you ever taken the prescription drug Fenfluramine, Fenfluramine combined with Phentermine (Fen-phen), Dexfenfluramine (Redux), or any other weight loss products Yes No

If yes, when _____

Please list:

Significant Illnesses (such as High Blood Pressure, Heart Disease, Cancer, Diabetes, etc): _____

Current medications: _____

Allergies: _____

Surgeries: _____

Any Complications? _____

Date of last Menstrual Cycle? _____

Please check if you've ever had any of the following:

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cosmetic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizzy/Fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/ Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatric Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Patient's Signature: _____ Date: _____ Reviewed by Dr: _____