Welcome

Account #

Patient's Name ______________________________ ______________________________
Last First Initial

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

1. Physician's Name ______________________________
   Address ______________________________
   ____
2. Are you under a physicians care?.. YES NO
   Since when? ______________ Why? ______________
3. When was your last complete physical exam? ______________
4. Are you taking any medications or substances? .... YES NO
   (If yes, please list medication in comments section or on the back of this form.)
5. Do you routinely take health related substances?.. YES NO
6. Are you allergic to any medications or substances?.. YES NO
7. Do you have any other allergies?.. YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics? or other medications?.. YES NO
9. Are you sensitive to any metals or latex?.. YES NO
10. Are you pregnant or suspect you may be?.. YES NO
11. Do you use any birth control medications?.. YES NO
12. Have you ever been treated for or been told you might have heart disease?............ YES NO
13. Do you have a pacemaker or an artificial heart valve implant?.. YES NO
14. Have you ever had rheumatic fever?.. YES NO
15. Are you aware of any heart murmurs?.. YES NO
16. Do you have high or low blood pressure?.. YES NO
17. Have you ever had a serious illness or major surgery?.. YES NO
    If so, explain ______________________________
18. Have you ever had radiation treatment, chemo treatment for tumor, Growth or other condition?.. YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism?.................. YES NO
20. Do you have any artificial joints/prosthesis?.. YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc?........................ YES NO
22. Have you ever bled excessively after being cut or injured?.. YES NO
23. Do you have any stomach problems?.. YES NO
24. Do you have any kidney problems?.. YES NO
25. Do you have any liver problems?.. YES NO
26. Are you diabetic?.. 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 venereal disease?.. YES NO
30. Have you tested HIV positive?.. YES NO
31. Do you have AIDS?.. YES NO
32. Have you had or do you test positive for hepatitis?.. YES NO
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 combined with 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 have not covered in this form? ______________________________
41. Would you like to speak to the doctor privately about any problem?.......................... YES NO

COMMENTS

Allergies:

Medication:

Hospitalizations:

HIV/Aids ___ Yes

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/GUARDIAN'S SIGNATURE ______________________________ DATE ____/____/____

DENTIST'S SIGNATURE ______________________________ DATE ____/____/____

MEDICAL HISTORY