MEDICAL HISTORY

PATIENT NAME: _		D.O.B.				
PRIMARY CARE I	PHYSICIAN'S NAME:					
	Date of Last Visit to Primary					
Physician:						
Have you ever taken any of	the group of drugs collectively referred to	as "fen-phen"? These include combination				
names of phentermine), Pon	adimin (fenfluramine), and Redux (defenflu	ramine)yes no Have you	a had any serious illnesses or			
operations in the last 5 years	s?yesno If yes, Describe:					
Have you ever had a blood t	transfusion?yesno If yes, give a	annroximate dates				
(Women) Are you pregnant	? ves no Nursing? ves	no Taking birth control pills?yes _	no			
Are you allergic to Bisulfite	es (a preservative)? yes no	Are you allergic to Latex?yes	no			
Are you allergic to any meta	als? yes no If yes, please list					
Do you have any mental, lea	arning or physical disabilities including hea	ring difficulties?yesno If yes pl	ease list:			
Check if you have any of the	e following:					
id Reflux		Hepatitis	Scarlet Fever			
ngina	Cortisone Treatments	Herpes	Shortness of Breath			
iemia	Cough, Persistent	High Blood Pressure	Skin Rash			
thritis, Rheumatism	Cough up Blood	HIV/AIDS	Stent			
tificial Heart Valve	Depression	Jaw Pain	Stroke			
tificial Joints	Diabetes	Joint Replacement	Swelling of Feet or			
thma	Eating Disorders	Kidney Disease	Ankles			
ck Problems	Epilepsy/seizures	Liver Disease	Thyroid Problems			
ood Disease	Eye Problems	Mitral Valve Prolapse	Tobacco Habit			
ncer	Fainting	Osteoporosis	Tonsillitis			
emical Dependency	Headaches	Pacemaker	Tuberculosis			
emotherapy	Heart Murmur	Radiation	Ulcer			
olesterol	Heart Problems	Respiratory Disease	Venereal Disease			
rculatory ALLERGIES:	Hemophilia	Rheumatic Fever	Other			
Please List ALL MEDICAT	TONS you are currently taking:					
Please List ALL VITAMINS	S and MINERAL SUPPLEMENTS you are cu	rrently taking:				
Please List ALL HERBAL S	SUPPLEMENTS you are currently taking:					
PATIENT/GUARDIAN SIG	GNATURE:	DATE:				
	U	JPDATES:				