Patient name ___________________________________ Date of Birth ___________

Address ____

City, State, zip ____

Phone number __________________________ cell / home / work *(please circle one)*

Email address ____

MEDICAL INFORMATION

Have you been hospitalized or under the care of a medical doctor in the last 2 years
Other than routine……………………………………………………………….. ....Yes No

Please list any medications you are currently taking____
____
____

Have you ever taken appetite suppressants-fen-phen -Fenfluramine & Phentermine or
Dexfenfluramine?...Yes No

Are you sensitive or allergic to any medications……………………………………………………..Yes No
____

Have you used or do you currently use tobacco products? If yes, which one:_________________________

Please circle to indicate which of the following you have had or have at the present.

Allergy to Latex	Cold Sores/Fever Blisters	HIV positive/AIDS
Allergy to Metal	Diabetes	Kidney Trouble
Allergies or Hives	Substance Abuse	Liver Disease
Anemia	Epilepsy/Seizures	Mitral Valve Prolapse
Angina Pectoris	Fainting/Dizziness	Osteoporosis
Arthritis	Heart Attack	Pacemaker
Artificial Heart Valve	Heart Disease	Radiation Therapy
Artificial Joints	Heart Murmur	Rheumatic Fever
Asthma	Heart Surgery	Stroke
Cancer	Hepatitis A B C	Thyroid Problems
Chemotherapy	High Blood Pressure	Tuberculosis

Do you have or have you had any disease, condition or problem not listed?......................................Yes No
If yes, please list:____
____

For Women: Are you pregnant? Yes No Are you nursing? Yes No Taking birth control pills? Yes No

Signature___________________________________ Date___________

Office use only: _______________