

## Health History

Physician's Name		er beginning did on your state of the same was		Date	of last visit	oran iak mai wanistan kantain manaistak ii ma
Have you ever taken any of the (brand names of phentermine	ne group of drugs e), Pondimin (fenfl	collectively referred to a uramine) and Redux (de	is "fen-phen?" T exfenfluramine).	hese inc	lude combinations of Ionimin	, Adipex, Fastin
Place a mark on "yes" or "no"	to indicate if you	have had any of the foll	owing:			
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes	□ No	Radiation Treatment	☐Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐Yes	□ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	Yes	□No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes	□No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐Yes	□No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	Yes	□No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type	Yes	□ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with	DAG DAG	Herpes	☐ Yes	□No	Special Diet	☐ Yes ☐ No
extractions or surgery Blood Disease	☐Yes ☐No	High Blood Pressure	☐ Yes	□No	Stroke	☐Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes	□No	Swollen Feet or Ankles	☐Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes		Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐Yes ☐No	Kidney Disease			Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐Yes		Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐Yes	□No	Tuberculosis	☐Yes ☐ No
Cortisone Treatments	☐Yes ☐No	Mitral Valve Prolapse Nervous Problems	☐ Yes		Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐Yes ☐No	Pacemaker	☐ Yes ☐ Yes		Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes		Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	r sychiatric Care	[_] les	TIMO	Weight Loss, unexplained	☐Yes ☐ No
Do you wear contact lenses?	☐ Yes [	JNo				
Women:						
Are you pregnant?	☐ Yes ☐	No Due date			Are you nursing?	? ☐ Yes ☐ No
Taking birth control pills?	☐ Yes ☐	] No				
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Med	dications			***************************************	Allergies	
List any medications you are	dications		☐Aspirin	***************************************	Allergies  □ Local Anestheti	C
List any medications you are diagnosis:	dications currently taking a	nd the correlating		s (Sleepi	***	c
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List any medications you are diagnosis:	dications currently taking a	nd the correlating	☐ Barbiturate	es (Sleepi	☐ Local Anestheti ng pills) ☐ Penicillin ☐ Sulfa	
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