



MEDICAL HISTORY

It is important that we know about your medical history. Many factors have a direct bearing on our health. We will review the questionnaire and discuss this with you in detail. Information provided below is strictly confidential and will not be released to anyone without your written permission.

Physician's Name: _____ Date of Last Physical Examination: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? Yes No If so, which drug? _____

Have you had any serious illnesses or operations? Yes No

If yes, please describe _____ Date: _____

Have you ever had a blood transfusion? Yes No If yes, give dates: _____

Are you Pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Do you have or have you had any of the following conditions (**Please mark Yes or No**):

- | | | | |
|---|--|---|--|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> <input type="checkbox"/> Stroke: |
| | | | When? _____ |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> Blood Disease | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |

Medications:

Please list ALL medications you are taking:

Allergies:

Please list any allergies: _____

SIGNATURE: _____ **DATE:** _____