Patient Medical History

Patient Name: ______________________________ Date: ____________

Do you currently have, or had at one time, any of the following?

A. Rheumatic Fever	Yes	No	B. Respiratory Condition	Yes	No
C. Heart Condition	Yes	No	D. Tuberculosis	Yes	No
E. Heart Murmur	Yes	No	F. Diabetes	Yes	No
G. Heart Surgery	Yes	No	H. Kidney Disease	Yes	No
I. Valve Replacement	Yes	No	J. Hepatitis/Jaundice	Yes	No
K. Pacemaker	Yes	No	L. HIV Positive	Yes	No
M. Stroke	Yes	No	N. Epilepsy/seizures	Yes	No
O. High Blood Pressure	Yes	No	P. Joint Replacement	Yes	No
Q. Prolonged Bleeding	Yes	No			

1. Are you taking any medications or pills, (prescribed or not) Yes No
   If yes, please list: ____
2. Are you allergic to any medicines, drugs or latex? Yes No
   If yes, please list: ____
3. Have you ever taken Phen Fen, Pondimin or Redux? Yes No
   If yes, please list: ____
4. Are you under the care of a physician or have within the past 6 months? Yes No
   IF yes, please explain: ____________________________________

   ____
5. Do you have any disease, condition or problem not listed above that we should be aware of? Yes No
   If yes, please explain: ____________________________________

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6. Are you currently or think you may be pregnant? Yes No

Patient Signature: ____________________________________