



Medical History

Name \_\_\_\_\_ Height \_\_\_\_\_' \_\_\_\_\_" Weight \_\_\_\_\_ lbs. Date \_\_\_\_\_

- 1. Are you in good health? Yes No
2. Any changes in your general health within the past year? Yes No
3. My last physical examination was on \_\_\_\_\_
4. Are you now under the care of a physician? Yes No
5. The name and address of my physician(s) is \_\_\_\_\_

- 8. Have YOU EVER or are you CURRENTLY taking any of the following?
Blood Thinners/Aspirin Yes No
Blood Pressure Medications Yes No
Insulin / Diabetes Medications Yes No
Steroids/Cortisone Yes No
Thyroid Medication Yes No
Heart Medications Yes No
Nitroglycerin Yes No
Fenfluramine (Pondimin) Yes No
Dexfenfluramine (Redux) Yes No
Phentermine Yes No
Fen / Phen Yes No
Bisphosphonates (Zometa, Actonel, Fosamax) Yes No

- 6. Have you ever been hospitalized in the past 5 years? Yes No
7. Are you ALLERGIC or have you ever experienced a reaction to any of the following?
Local Anesthetic Yes No
Penicillin or Other Antibiotics Yes No
Sulfa Drugs Yes No
Barbiturates, Sedatives, Narcotics Yes No
Aspirin Yes No
Iodine Yes No
Codeine Yes No
Other Yes No

- 9. Please list all medications and dosages below
10. Do you smoke? If yes how much? Yes No
11. Do you drink alcohol? If yes how much? Yes No
12. Do you use any illicit drugs or medications? Yes No

13. Do you HAVE or have you EVER had any of the following?

Table with 6 columns: GENERAL, YES, NO, CARDIOVASCULAR, YES, NO, RESPIRATORY, YES, NO. Rows include symptoms like Tire Easily, Weakness, Rheumatic Fever, Tuberculosis, etc.