PATIENT IN	IFORMATION	V					
Name			Birthdate		SS#	SS#	
Address			City		State	Zip	
Sex M F	☐ Married ☐ Separated	☐ Widowed	☐ Single	☐ Minor			
Home Phone		Cell Phone			Email		
Spouse or Parent's Name					Work Phone		
Whom may we than	<u> </u>			What's the best			
Person to contact in							
MEDICAL H				_			
			-	Date of last visit			
•		drugs collectively referr					
	,	amine) and Redux (dex	(fenfluramine).	□Yes □No			
•	•		∐Yes	If yes, describe	-		
Have you ever had a	blood transfusion?	☐Yes ☐No		If yes, give app	roximate dates		
(Women) Are you pr	egnant? Yes	s ∏No Nu	ı <mark>rsing?</mark>	□No	Taking birth control	pills? Yes No	
Y N Anemia Arthritis, Rhe Artificial Hear Artificial Joint Asthma Back Problen Bleeding Abr Blood Diseas Cancer Chemical De Chemotherap Circulatory P List medications you	rt Valves ts, Pins, etc. ns normally be pendency	Y N Congenital Hea Cortisone Trea Cough, Persist Cough up Blood Diabetes Epilepsy Epilepsy Glaucoma Headaches Heart Murmur Heart Problems Hemophilia	atments tent od	Y N Hepititis Hernia F High Blo HIV/AID Jaw Pai Kidney I Mitral Va Radiatio Respira	Repair pod Pressure S n Disease sease alve Prolapse aker n Treatment tory Disease	Y N Scarlet Fever Shortness of Breath Skin Rash Stroke Swelling of Feet or Ank Thyroid Problems Tobacco Habit Tonsillitis Tuberculosis Ulcer Venereal Disease	
Allergies:							
Y N	Aspirin		etic	Y N Iodine Latex None	Y N	Other	
	nowledge, the above i ave a change in healt	information is complete th.	and correct. I ui	nderstand that it is my	responsibility to inform	n my doctor if I, or my	
	Signature of of P	atient, Parent, Guardia	n or Personal Re	epresentative		Date	
Please print name of Patient, Parent, Guardian or Personal Representative						Relationship to Patient	