

**PATIENT INFORMATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F  Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered s  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Spouse or Parent's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_ What's the best way to reach you? \_\_\_\_\_  
 Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 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), Pndimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No  
 Have you ever had any serious illnesses or operations??  Yes  No If yes, describe \_\_\_\_\_  
 Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_  
 (Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had problems with any of the following:

- |   |  |   |  |
|---|--|---|--|
| <b>Y N</b>  | <b>Y N</b>   | <b>Y N</b>  | <b>Y N</b>   |
| <input type="checkbox"/> <input type="checkbox"/> Anemia                        | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart lesions | <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"/> Cortisone Treatments     | <input type="checkbox"/> <input type="checkbox"/> Hernia Repair         | <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, Persistent        | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> <input type="checkbox"/> Cough up Blood           | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                        | <input type="checkbox"/> <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain              | <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"/> Epilepsy                 | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Abnormally           | <input type="checkbox"/> <input type="checkbox"/> Fainting                 | <input type="checkbox"/> <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> <input type="checkbox"/> Tobacco Habit              |
| <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"/> Tonsillitis                |
| <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"/> Tuberculosis               |
| <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"/> Ulcer                      |
| <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"/> Venereal Disease           |
| <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/> <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever       |  |

List medications you are currently taking: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Allergies:

<b>Y N</b>	<b>Y N</b>	<b>Y N</b>	<b>Y N</b>
<input type="checkbox"/> <input type="checkbox"/> Aspirin	<input type="checkbox"/> <input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> <input type="checkbox"/> Iodine	<input type="checkbox"/> <input type="checkbox"/> Other _____
<input type="checkbox"/> <input type="checkbox"/> Barbiturates (Sleeping Pills)	<input type="checkbox"/> <input type="checkbox"/> Penicillin	<input type="checkbox"/> <input type="checkbox"/> Latex	_____
<input type="checkbox"/> <input type="checkbox"/> Codeine	<input type="checkbox"/> <input type="checkbox"/> Sulfa	<input type="checkbox"/> <input type="checkbox"/> None	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

\_\_\_\_\_  
 Signature of of Patient, Parent, Guardian or Personal Representative Date  
 \_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

**Payment is due in full at time of treatment unless prior arrangements have been approved.**

