

# MEDICAL HISTORY REVIEW

## 1 Patient Information

Date _____	Cell Phone # _____	Patient ID #(for office use) _____
Patient Name _____		
First Name	Middle Initial	Last Name

## 2 Health 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 loimin, Adipex, Fastin (phentermine) , Pondimin (fenfluramine) and Redux (dexfenfluramine). <input type="checkbox"/> Y <input type="checkbox"/> N		
Place a mark on "yes" or "No" to indicate if you have had any of the following:		
AIDS/HIV <input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N	Respiratory Disease <input type="checkbox"/> Y <input type="checkbox"/> N
Anemia <input type="checkbox"/> Y <input type="checkbox"/> N	Fainting or dizziness <input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatic Fever <input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis, Rheumatism <input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma <input type="checkbox"/> Y <input type="checkbox"/> N	Scarlet Fever <input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Heart Valves <input type="checkbox"/> Y <input type="checkbox"/> N	Headaches <input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of Breath <input type="checkbox"/> Y <input type="checkbox"/> N
Artificial Joints <input type="checkbox"/> Y <input type="checkbox"/> N	Heart Murmur <input type="checkbox"/> Y <input type="checkbox"/> N	Sinus Trouble <input type="checkbox"/> Y <input type="checkbox"/> N
Asthma <input type="checkbox"/> Y <input type="checkbox"/> N	Heart Problems <input type="checkbox"/> Y <input type="checkbox"/> N	Skin Rash <input type="checkbox"/> Y <input type="checkbox"/> N
Back Problems <input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis Type ___ <input type="checkbox"/> Y <input type="checkbox"/> N	Smoker <input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding abnormally, with Extractions or surgery <input type="checkbox"/> Y <input type="checkbox"/> N	Herpes <input type="checkbox"/> Y <input type="checkbox"/> N	Special Diet <input type="checkbox"/> Y <input type="checkbox"/> N
Blood Disease <input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	Stroke <input type="checkbox"/> Y <input type="checkbox"/> N
Cancer <input type="checkbox"/> Y <input type="checkbox"/> N	Jaundice <input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Feet or Ankles <input type="checkbox"/> Y <input type="checkbox"/> N
Chemical Dependency <input type="checkbox"/> Y <input type="checkbox"/> N	Jaw Pain <input type="checkbox"/> Y <input type="checkbox"/> N	Swollen Neck Glands <input type="checkbox"/> Y <input type="checkbox"/> N
Chemotherapy <input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Problems <input type="checkbox"/> Y <input type="checkbox"/> N
Circulatory Problems <input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease <input type="checkbox"/> Y <input type="checkbox"/> N	Tonsillitis <input type="checkbox"/> Y <input type="checkbox"/> N
Congenital Heart Lesions <input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N
Cortisone Treatments <input type="checkbox"/> Y <input type="checkbox"/> N	Mitral Valve Prolapse <input type="checkbox"/> Y <input type="checkbox"/> N	Tumor or growth on head or neck <input type="checkbox"/> Y <input type="checkbox"/> N
Cough, persistent/bloody <input type="checkbox"/> Y <input type="checkbox"/> N	Nervous Problems <input type="checkbox"/> Y <input type="checkbox"/> N	Ulcer <input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N	Pacemaker <input type="checkbox"/> Y <input type="checkbox"/> N	Venereal Disease <input type="checkbox"/> Y <input type="checkbox"/> N
Emphysema <input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Care <input type="checkbox"/> Y <input type="checkbox"/> N	Wear contact lenses <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Women:</b> Are you pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N	Due Date _____	Are you nursing? <input type="checkbox"/> Y <input type="checkbox"/> N
Taking birth control pills? <input type="checkbox"/> Y <input type="checkbox"/> N		

<p><b>MEDICATIONS</b></p> <p>List any medications you are currently taking and the correlating diagnosis: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Pharmacy Name _____</p> <p>Phone(____) _____</p>	<p><b>ALLERGIES</b></p> <table style="width: 100%;"> <tr> <td>___ Aspirin</td> <td>___ Local Anesthetic</td> </tr> <tr> <td>___ Barbiturates (Sleeping Pills)</td> <td>___ Penicillin</td> </tr> <tr> <td>___ Codeine</td> <td>___ Sulfa</td> </tr> <tr> <td>___ Iodine</td> <td>___ Other _____</td> </tr> <tr> <td>___ Latex</td> <td>_____</td> </tr> </table>	___ Aspirin	___ Local Anesthetic	___ Barbiturates (Sleeping Pills)	___ Penicillin	___ Codeine	___ Sulfa	___ Iodine	___ Other _____	___ Latex	_____
___ Aspirin	___ Local Anesthetic										
___ Barbiturates (Sleeping Pills)	___ Penicillin										
___ Codeine	___ Sulfa										
___ Iodine	___ Other _____										
___ Latex	_____										

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date