Patient Name: _____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTIONS

1. Physician's Name: _____
   Address: _____ phone number: _____

2. Are you under a physician's care? yes/no
   Since when: _____ Why: _____

3. When was your last complete physical exam: _____
4. Are you taking any medications or substances? yes/no
   (please list —>)
5. Do you routinely take health related substances? yes/no
   please list —>
6. Are you allergic to any medications or substances:? yes/no
   please list: _____
7. Do you have any allergies? yes/no
   please list: _____
8. Do you have any problems with: penicillin, antibiotics, anesthetics or other medications? yes/no
   please list: _____
9. Are you sensitive to any metals or latex? yes/no
   please list: _____ _____
10. Are you pregnant or suspect you may be? yes/no
11. Do you use any birth control medications? yes/no
12. Have you ever been treated for or been told you might have a heart disease? yes/no
    If yes: when/physician: _____
13. Do you have a pacemaker or an artificial heart valve implant? yes/no
14. Have you ever had rheumatic fever? yes/no
15. Are you aware of any heart murmurs? yes/no
16. Do you have high or low blood pressure? yes/no
    which one: _____
17. Have you ever had a serious illness or major surgery? yes/no
    please list in box ————>
18. Have you ever had radiation treatment, chemo treatment? yes/no
    Please list for which condition: _____
19. Are you or have you been on a bone density drug? yes/ no
    please list: _____
20. Do you have an inflammatory disease such as arthritis, rheumatism? yes/no
    please list which conditions: _____
21. Do you have artificial joints / prosthesis? yes/no
    please list: _____
22. Do you have stomach problems? yes/no
23. Do you have and blood disorders such as anemia, leukemia etc? yes/no
    please list conditions: _____
24. Have you ever bled excessively after being cut or injured? yes/ no
25. Do you have any kidney problems? yes/no
26. Do you have any liver problems? yes/no
27. Are you diabetic? yes/no
28. Do you have asthma? yes/no
29. Do you have epilepsy or seizure disorders? yes/no
30. Do you have or have had a venereal disease? yes/no
31. Have you tested HIV positive? yes/no
32. Do you have AIDS? yes/no

Please list medications and or health related substances:

Please list surgeries / illnesses and dates:

33. Have you had or do you test positive for hepatitis? yes/no
34. Do you have or have you had T.B.? yes/no
35. Do you smoke, chew, use snuff or any other form of tobacco: yes/no
36. Do you consume alcoholic beverages? yes/ no
37. Do you habitually use controlled substances? yes/no
38. Have you had psychiatric treatment? yes/no
39. Have you ever used prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? yes/no
    please list: _____
40. Do you have any disease, condition or problem not listed? yes/no
    please list _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT / GUARDIAN'S SIGNATURE: _____ DATE: _____

MEDICAL HISTORY