

Patient's Name \_\_\_\_\_

**HEALTH/MEDICAL HISTORY**

**DIRECTIONS:** Please circle either YES or NO on each question. Please use pen. If you have any questions, please do not hesitate to ask a team member.

1. Are you in good health?.....YES NO  
 a. Has there been any change in your  
 general health within the past year? YES NO

2. My last physical was on \_\_\_\_\_

3. Are you under the care of a physician? YES NO  
 if so, what is the condition being treated  
 \_\_\_\_\_

4. The name, address & phone number of my physician  
 is: \_\_\_\_\_  
 \_\_\_\_\_

5. Have you had any serious illness,  
 operation, or been hospitalization? YES NO

6. If so, what was the illness or operation?  
 \_\_\_\_\_  
 \_\_\_\_\_

7. Are you now taking, or have you ever taken, any of  
 the following:

- |  |     |    |
|--|-----|----|
| Antibiotics or sulfa drugs   | YES | NO |
| Anticoagulant (blood thinners)   | YES | NO |
| High Blood Pressure medicine   | YES | NO |
| Cortisone (steroids)   | YES | NO |
| Tranquilizers  | YES | NO |
| Aspirin  | YES | NO |
| Insulin, or similar drug   | YES | NO |
| Digitalis or drugs for heart trouble   | YES | NO |
| Nitroglycerin  | YES | NO |
| Antihistamine  | YES | NO |
| Thyroid or other hormone drugs   | YES | NO |
| Fosamax/bisphosphonates or any<br>drugs for osteoporosis, osteopenia,<br>bone cancer | YES | NO |

Please list ALL medication you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Are you allergic or have you reacted adversely to:

Local anesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Barbiturates, sedatives, sleeping pills	YES	NO
Aspirin	YES	NO
Iodine	YES	NO
Codeine or other narcotics	YES	NO
Latex	YES	NO

Any other drugs or medications *allergic* to:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Did you ever take PHEN/PHEN diet drugs? YES NO

10. Do you have or have you had any of the following  
 problems?

- |   |     |    |
|---|-----|----|
| Rheumatic fever or rheumatic heart<br>disease   | YES | NO |
| Congenital heart lesions  | YES | NO |
| Cardiovascular disease (heart<br>trouble, heart attack, coronary<br>insufficiency, coronary occlusion,<br>arteriosclerosis, stroke) | YES | NO |
| High blood pressure   | YES | NO |
| Heart murmurs   | YES | NO |
| Mitral Valve Prolapse   | YES | NO |
| Allergy/hay fever   | YES | NO |
| Asthma  | YES | NO |
| Hives or skin rash  | YES | NO |
| Fainting spells or seizures   | YES | NO |
| Diabetes  | YES | NO |
| Hepatitis, jaundice or liver disease  | YES | NO |
| Arthritis   | YES | NO |
| Inflammatory rheumatism(painful,<br>swollen joints)   | YES | NO |
| Stomach ulcers  | YES | NO |
| Kidney trouble  | YES | NO |

