

Health History

Physician's Name _____ Date of Last Visit / / Tel. No. ()

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 phenetermine), Pondimin (fenfluramine) and Reduc (dexfenfluramine) Yes No

Please place a mark on "yes" or "no" to indicate if you have ever had or currently have any of the following:

AIDS/HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Radiation Tx	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fainting or Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Respiratory Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Heart Valves	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
Artificial Joints	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinus Trouble	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis (Type _____)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Skin Rash	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bleeding abnormally	Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Special Diet	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Bld. Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Feet or Ankles	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Dependency	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaw Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen Neck	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
Circulatory Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tonsillitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Congenital Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Bld. Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cortisone Treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mitral Valve Prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tumors	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cough (Persistent)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>	Venereal Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Psychiatric Care	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss (unexplained)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you wear contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

Women:

Are you pregnant? Yes No Due Date: / / Are you Nursing? Yes No

Taking Birth Control Pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis
(Either Prescription or Over The Counter)

Pharmacy Name: _____

Phone () -

Allergies

Aspirin	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>
Sleeping Pills	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	Other: _____	
Latex	<input type="checkbox"/>	_____	

Please provide any additional medical/dental information that you feel may be of help in determining your treatment.

