

DOCTOR INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____
LAST FIRST M MO DAY YR

ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? NO YES – WHY: _____

MEDICAL DOCTOR'S NAME: _____

HAVE YOU HAD ANY OPERATIONS: NO YES – EXPLAIN: _____

HAVE YOU BEEN HOSPITALIZED: NO YES – EXPLAIN: _____

HAVE YOU EVER TAKEN FEN-PHEN: NO YES

(WOMEN) ARE YOU OR DO YOU THINK YOU ARE PREGNANT: NO YES

DO YOU CURRENTLY TAKE ANY MEDICATION: NO YES – LIST: _____

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Joint/Hip Replacement | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis A - B - C | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Allergies (Please List) _____ | <input type="checkbox"/> Other Illnesses not listed above: _____ | | |

X _____ DATE: _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

REVIEWED BY: DOCTOR _____ DATE: _____ B.P. _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

MEDICAL UPDATES

MY SIGNATURE(S) BELOW INDICATE THAT I HAVE READ & UPDATED MY MEDICAL HISTORY.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____
_____	_____	None <input type="checkbox"/> _____	_____	DR. _____