

Present Status	1. Are you in good health at the present time to the best of your knowledge? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
	2. Are you under a doctor's care at the present time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what?																																								
	3. Are you taking any medications at the present time? Please List <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
	4. Any allergies to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
	5. Are you taking or have you taken Pondimin or Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
	6. Are you taking or have you ever taken Meridia (Sibutramine) ? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
	7. Are you currently on an ANTIDEPRESSANT? <input type="checkbox"/> Yes <input type="checkbox"/> No Serotonin Uptake Inhibitors such as Prozac, Zoloft, Paxil, Luvox, Effexor, MAO Inhibitors such as Nardil, Parnate, or Eldepryl																																								
	8. Are you currently on Phentermine, Ionamin, or Bontril? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
Past Medical History	9. History of Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, at what age	<p>19. Your Past History. Check all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Jaundice</td> <td><input type="checkbox"/>Kidney Disease</td> <td><input type="checkbox"/> Thyroid Disease</td> </tr> <tr> <td><input type="checkbox"/>Lung Disease</td> <td><input type="checkbox"/>Rheumatic Fever</td> <td><input type="checkbox"/> Ulcers</td> </tr> <tr> <td><input type="checkbox"/>Anemia</td> <td><input type="checkbox"/> Tuberculosis</td> <td><input type="checkbox"/> Drug Abuse</td> </tr> <tr> <td><input type="checkbox"/>Pneumonia</td> <td><input type="checkbox"/> Cholera</td> <td><input type="checkbox"/>Arthritis</td> </tr> <tr> <td><input type="checkbox"/>Malaria</td> <td><input type="checkbox"/> Osteoporosis</td> <td><input type="checkbox"/> Psychiatric Illness</td> </tr> <tr> <td><input type="checkbox"/>Measles</td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/> Scarlet Fever</td> </tr> <tr> <td><input type="checkbox"/>Gout</td> <td><input type="checkbox"/> Eating Disorder</td> <td><input type="checkbox"/>Whooping Cough</td> </tr> <tr> <td><input type="checkbox"/>Polio</td> <td><input type="checkbox"/> Bleeding Disorder</td> <td><input type="checkbox"/>Blood Transfusion</td> </tr> <tr> <td><input type="checkbox"/>Heart Disease</td> <td><input type="checkbox"/> Pleurisy</td> <td><input type="checkbox"/> Gallbladder Disorder</td> </tr> <tr> <td><input type="checkbox"/>Tonsillitis</td> <td><input type="checkbox"/>Thyroid Disease</td> <td><input type="checkbox"/> Nervous Breakdown</td> </tr> <tr> <td><input type="checkbox"/>Cancer</td> <td><input type="checkbox"/>Chicken Pox</td> <td><input type="checkbox"/>Heart Valve Disorder</td> </tr> <tr> <td><input type="checkbox"/>Liver Disease</td> <td><input type="checkbox"/> Alcohol Abuse</td> <td><input type="checkbox"/>Typhoid Fever</td> </tr> <tr> <td colspan="3"><input type="checkbox"/>Other (Please specify)_____</td> </tr> </table>	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Anemia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Cholera	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Malaria	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Gout	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Polio	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Gallbladder Disorder	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Nervous Breakdown	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Valve Disorder	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Typhoid Fever	<input type="checkbox"/> Other (Please specify)_____		
	<input type="checkbox"/> Jaundice		<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease																																					
	<input type="checkbox"/> Lung Disease		<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcers																																					
	<input type="checkbox"/> Anemia		<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Drug Abuse																																					
	<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Cholera	<input type="checkbox"/> Arthritis																																					
	<input type="checkbox"/> Malaria		<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Psychiatric Illness																																					
	<input type="checkbox"/> Measles		<input type="checkbox"/> Mumps	<input type="checkbox"/> Scarlet Fever																																					
	<input type="checkbox"/> Gout		<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Whooping Cough																																					
	<input type="checkbox"/> Polio		<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Blood Transfusion																																					
	<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Gallbladder Disorder																																					
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Nervous Breakdown																																							
<input type="checkbox"/> Cancer	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Valve Disorder																																							
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Typhoid Fever																																							
<input type="checkbox"/> Other (Please specify)_____																																									
10. History of High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
11. History of Heart Attack or Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
12. History of Swelling Feet/Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
13. History of Frequent Headaches? Migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
14. History of Constipation ? <input type="checkbox"/> Yes <input type="checkbox"/> No History of Diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
15. History of Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No																																									
16. Any serious Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please list _____																																									
17. Any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list _____																																									
18. Has any blood relative had any of the following (specify the relationship)																																									
<input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> Asthma _____ <input type="checkbox"/> Epilepsy _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Tuberculosis _____ <input type="checkbox"/> Kidney Disease _____ <input type="checkbox"/> Osteoperosis _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Thyroid Disease _____ <input type="checkbox"/> Psychiatric Disease _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> High Blood Pressure _____																																									
<p>WOMEN ONLY-GYNEOLOGICAL HISTORY</p> <p>Any Pregnancies? Number _____ List the Year(s)</p> <p>Natural Delivery _____ C-Section _____</p> <p>Menstrual: Onset _____ Duration _____ Are they regular? <input type="checkbox"/>Yes <input type="checkbox"/>No Pain Associated? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Last menstrual period: _____</p> <p>Hormone Replacement Therapy (specify) _____</p> <p>Birth Control Pills? What type? _____</p> <p>Last Check Up _____</p>																																									
DOCTOR	20. Does your primary care physician know that you are interested in losing weight? <input type="checkbox"/>Yes <input type="checkbox"/>No																																								
	21. If there is a need, do you give us permission to contact your primary care physician? <input type="checkbox"/>Yes <input type="checkbox"/>No																																								
	22. Primary Care Physician Name:	24. Physician City/State:																																							
	23. Primary Care Physician Phone:	25. Date of your last checkup																																							
	26. Specialist Name:	27.Specialist Phone:																																							
	28. Specialist Name	29.Specialist Phone:																																							
By signing this form, I confirm that all the information is true and I have not omitted any information that may affect my medical treatment.																																									
Patient Signature _____ Date _____																																									

