

HISTORY FORM

Patient Name: _____ **Date of Birth:** _____ **Page One**

Are you allergic to any medications? YES NO If yes list below:
 1. _____ 2. _____

Have you ever had dental anesthesia (Lidocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):
 1. _____ 3. _____ 5. _____
 2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Chronic Bronchitis			Diabetes		
Emphysema			Excessive thirst/hunger		
Asthma			Amputation		
Cardiovascular:			Thyroid		
High Blood Pressure			Kidney		
Chest Pain			Dialysis		
Heart Attack/Failure			Bladder		
Heart Murmur			Frequency/burning		
Irregular Heartbeat			Gastrointestinal		
Blood Clots/Stroke			Stomach absorptive disorder		
Mental Health Disorders			Hepatitis		
Alzheimer's			Arthritis/Joint Deformity		
Drug Abuse			Arthralgia		
Anxiety Depression			Limited Motion		
Eating Disorder			Artificial Joint		
History of Glaucoma			Convulsions, epilepsy, Seizures, Fainting		

List any other diseases or conditions: _____

List any surgeries _____

Social History:

Do you drink alcohol? YES NO If Yes _____ drinks per day

Do you use IV drugs? YES NO If Yes _____ what/how often

Do you smoke? YES NO If Yes _____ how often

(Women) Are you pregnant? YES NO

(Women) Are you breastfeeding? YES NO

What kind of diet programs have you tried in the past? _____

Have you ever used diet pills before? YES NO

Have you ever used any of the following? (Circle ones used)

TENUATE TEMANIL PRELUDE II PHEN/FEN PHENTERMINE (IONAMINE, FASTIN, ADIPEX)
 MERIDIA REDUX DIDREX PHENDIMETRAZINE OTHER_____

How much weight did you lose? _____

How long did you keep it off? _____

How much weight did you gain back? _____ LBS

What is your reason for being here today?

Appearance Health Work Family Spouse Other

FAMILY HISTORY

Any history of parents, grandparents, or siblings with the following:

Diabetes _____ Heart attack _____ Cancer _____ High blood pressure _____

Patient herein represents that they have disclosed all pertinent information regarding health profile to the provider of services during their examination. Patient further represents and guarantees that they have disclosed all medications they are currently consuming to this provider of services during their respective examination and from whom, if any, they are obtaining medications.

This provider of services makes a determination based on full disclosure from the patient.

This provider of services reserves the right to limit any patient’s medications to an appropriate amount based on the disclosed information from the patient during the examination.

Should information be obtained that in any way suggests false representations were made to this provider of service by the patient, the patient forever waives any right to any claim made against this provider of service and the clinic.

THE PATIENT UNDERSTANDS THAT IF THEY LOSE THEIR MEDICATION WHICH IS DISPENSED ON A WEEKLY OR MONTHLY BASIS, THEY WILL NOT BE ABLE TO OBTAIN A NEW SUPPLY UNTIL THE FOLLOWING WEEK OR MONTH. Patient also understands that the medications can not be returned or refunded once they have been dispensed. Patient also understands that if they go to another provider of service during the time frame of their treatment at this clinic, they are to notify this clinic and its representatives immediately of any other medications they might be receiving and that said notification must be executed in writing by and between this clinic and or its representative and the patient. The patient is also entitled to a copy of this notification after executed.

I the undersigned understand that I will be taking the medication provided by the clinic for the sole purpose of losing weight.

I have been advised of the side effects and effects that this medication may produce, and further have been advised that if adverse side effects are realized to stop the medication and call the doctor’s office.

I will UNDER NO CIRCUMSTANCES, transfer, sell, or give this medication to any other person or entity.

Patient Signature

Date

OFFICE USE:

I have reviewed line by line with the patient all items listed on pages 1 & 2 of this history form.

MD/PA/NP

Patient Name: _____ **Date of Birth:** _____ **Page Two**