Your Name:____ Date of Birth: __/__/____
Last First Init.

Please circle the appropriate answer. If you don't know the correct answer, please write "Don't Know" on the line after the question. If you answer yes, and there is an arrow to the right ("**YES>**"), please add any appropriate explanation in the comment box to the right. Thank you for your help.

				COMMENTS:
1.	Physician's name: City and Phone # (if known):	NO	YES	
2.	Are you currently under a physicians care? For what condition?	NO	YES	
3.	When was your last complete physical examination?	NO	YES	
4.	Are you taking any medication or substances? (If yes, please list medications in the "Comments" box to the right)	NO	YES	
5.	Are you allergic to any medications or substances? (if yes, please explain at right)	NO	**>YES>**	
6.	Do you have any problems with penicillin, antibiotics, anesthetics, or other medications?	NO	**>YES>**	
7.	Are you sensitive to any metals or latex?	NO	**>YES>**	
8.	Are you pregnant or suspect that you may be?	NO	YES	
9.	Do you use any birth control medications?	NO	YES	
10.	Have you ever been treated for or been told you might have heart disease?	NO	**>YES>**	
11.	Do you have a pacemaker or an artificial heart valve implant?	NO	YES	
12.	Have you ever had rheumatic fever?	NO	YES	
13.	Are you aware of any heart murmurs?	NO	YES	
14.	Do you have high or low blood pressure?	NO	YES	
15.	Have you ever had a serious illness or major surgery? If so, please explain here or in box at right:	NO	**>YES>**	
16.	Have you ever had radiation treatment or chemo therapy?	NO	**>YES>**	
17.	Do you have inflammatory diseases, such as arthritis or rheumatism?	NO	YES	
18.	Do you have any artificial joints or prosthesis?	NO	YES	
19.	Do you have any blood disorders, such as anemia, leukemia, etc.?	NO	**>YES>**	
20.	Have you ever bled excessively after being cut or injured?	NO	YES	
21.	Do you have any stomach problems?	NO	**>YES>**	
22.	Do you have any kidney problems?	NO	**>YES>**	
23.	Do you have any liver problems?	NO	**>YES>**	
24.	Are you diabetic?	NO	YES	
25.	Do you have asthma?	NO	YES	
26.	Do you have epilepsy or seizure disorders?	NO	YES	
27.	Do you or have you had a venereal disease?	NO	YES	
28.	Have you ever tested positive to HIV infection or AIDS?	NO	YES	
29.	Have you ever tested positive for hepatitis (other than hepatitis A)?	NO	YES	
30.	Do you or have you had T.B.?	NO	YES	
31.	Do you smoke, chew, use snuff, or any other form of tobacco?	NO	YES	
32.	Do you consume alcoholic beverages?	NO	YES	
33.	Do you habitually use controlled substances, especially cocaine?	NO	YES	
34.	Have you had psychiatric treatment?	NO	YES	
35.	Have you taken the prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dextenfluramine (redux), or other weight loss products?	NO	YES	
36.	Would you like to speak to Dr. Hart in private about any problem?	NO	YES	
37.	Do you have any disease, condition, or problem not listed? Is so, please explain here or in box at right:	NO	**>YES>**	
38.	Is there anything else we should know about your health that we have not covered in this form? If so, please explain here or in box at right:	NO	**>YES>**	

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE & ACCURATE: ____________________

DATE: ____________________

MEDICAL HISTORY