	Name			MEDICAL HISTORY						
Patient	Account No.				Medical Alert					
1.					THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN	one (	)_			
	Have you had any medical care w Describe	ithin th	e past t	two years?					Yes	No
2.	Have you taken any medication of	r drugs	during	the past two years?	?				Yes	No
3.	Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin?									No
	If yes, please list name and dosage									
4.	Have you ever taken prescription medications for weight loss (diet pills)?  If yes, did you take any of the following? (circle if yes)  Fen-Phen  Pondimen  Redux  Other									No
	If yes, did you take any of the followard for the following the storage of the above, did you								Yes	No
5	Have you ever taken bone loss pr								Yes	No
6.	Are you aware of having an allerg								Yes	No
	If yes, please specify									
7.	Have you been a patient in the ho	spital o	during th	he past five years?					Yes	No
8.	Indicate which of the following yo	u have	had, or	have at present. C	ircle "yes" or "n	o" to ea	ach item.			
	Heart (Surgery, Disease, Attack)	Yes	No	Ulcers		Yes	No	Hepatitis A B C (circle)	Yes	No
	Chest Pain	Yes	No	Diabetes			No	Venereal Disease		No
	Congenital Heart Disease	Yes	No	Thyroid Problems			No	A.I.D.S./H.I.V. Positive	Yes	No
	Heart Murmur	Yes	No	Glaucoma		Yes	No	Cold Sores/Fever Blisters	Yes	No
	High/Low Blood Pressure	Yes	No	Contact lenses		Yes	No	Blood Transfusion		No
	Mitral Valve Prolapse	Yes	No	Emphysema			No	Hemophilia		No
	Artificial Heart Valve/Pacemaker	Yes	No	Chronic Cough			No	Sickle Cell Disease		No
	Rheumatic Fever	Yes	No	Tuberculosis			No	Bruise Easily		No
	Arthritis/Rheumatism  Cortisone Medicine	Yes	No No	Asthma Hay Fever/Allergy			No No	Liver Disease/Yellow Jaundice  Neurological Disorders		No No
	Swollen Ankles	Yes	No	Latex Sensitivity			No	Epilepsy or Seizures		No
	Stroke		No	Sinus Trouble			No	Fainting or Dizzy Spells		No
	Diet (Special/Restricted)		No	Radiation Therapy			No	Nervous/Anxious		No
	Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy		Yes	No	Psychiatric/Psychological Care	Yes	No
	Kidney Trouble	Yes	No	Tumors		Yes	No			
9.	Have you lost or gained more than	10 pc	ounds in	the past year?					Yes	No
10.	Do you have or have you had any	diseas	se, cond	dition, or problem no	ot listed?				Yes	No
	If yes, please list:									
	Women: Are you pregnant or the									
12.	Do you use birth control prescript	ions?.							Yes	No
3	understand the above informanswered all questions to the ask the respective health care any change in my health or r	e bes re pro	t of m	y knowledge. Shor agency, who	nould further	inforn	nation b	be needed, you have my pe	ermissi	ion to
	atient/Guardian Signature							Date		
P										