PATIENT INFORMATION

CHART #1

Full Name_____ Date of Birth _____

Are you allergic to any vitamins? YES ____ NO ____ Social Security #_____

Are you allergic to any medications? YES____ NO ____

If so, please list them _____

Are you currently taking any type of medication including oral contraceptives? YES____ NO ____

If so, please list them and the dosage _____

Personal History of: (Please answer)

Hypertension — (High Blood Pressure)	YES ____ NO ____
Diabetes	YES ____ NO ____
Heart Disease	YES ____ NO ____
Angina Pectoris — (Chest Pain after Exercise)	YES ____ NO ____
Thyroid Disease	YES ____ NO ____
Cysts of Breast or Ovaries	YES ____ NO ____
Epilepsy	YES ____ NO ____
Substance Abuse	YES ____ NO ____
Alcoholism	YES ____ NO ____
Migraine Headaches	YES ____ NO ____
Psychiatric Illness — (Nervous Problem)	YES ____ NO ____

When was your last menstrual period? _____

Do you have any reason to believe you are pregnant? YES____ NO ____

Have you taken appetite suppressant medication before? YES____ NO ____

I have answered the above questions to the best of my knowledge.

Signature:_____ Date: _____