Health History

Name_____ Date of Birth_____

Are you currently under the care of a Physician? _____

If yes, for what reason? _____

Have you ever had or have any of the following?

Liver disease _____	High Blood Pressure _____	Epilepsy_____
Heart disease _____	Angina pectoris _____	Diabetes _____
Thyroid disease_____	Cyst of brst/ovaries _____	Cancer _____
Substance abuse _____	Migraine Headaches _____	Tobacco Use _____
Psychiatric illness _____	Alcoholism _____	Other, Please List _____

Are you Currently Breast Feeding or Pregnant? _____

Have you any recent surgeries, including cosmetic surgery? If yes, what?

_____

Are you currently taking any medication (s)? _____

If YES, what is/are the name (s), and for what reason? _____ _____

Have you taken an appetite suppressant before? If yes what is the name? _____

How long did you take the medication for? _____

When did you take it last? _____

Did you have any side effects from the medication? _____

If yes, what? _____

Do you suffer from any allergies? If yes, what? _____

Are you allergic to any medications? If yes, please list _____

Have you, or do you currently smoke? _____

I have answered the above health questionnaire to the best of my knowledge.

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date