# MD DIET/SERENITY MD
# 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 |
|---|---|---|---|---|---|
| Bronchitis | | | Diabetes | | |
| Emphysema | | | Excessive thirst/hunger | | |
| Asthma | | | Amputation | | |
| Chronic Cough | | | Thyroid | | |
| Morning Cough | | | Kidney | | |
| Shortness of Breath | | | Dialysis | | |
| Wheezing | | | Bladder | | |
| **Cardiovascular:** | | | Frequency/burning | | |
| High Blood Pressure | | | Gastrointestinal | | |
| Chest Pain | | | Stomach absorptive disorder | | |
| Heart Attack | | | Nausea, vomiting, diarrhea w/antibiotics | | |
| Heart Murmur | | | Hepatitis | | |
| Irregular Heartbeat | | | Yeast infection w/antibiotics | | |
| Phlebitis | | | Arthritis/Joint Deformity | | |
| Inflammation of vein | | | Arthralgia | | |
| **Mental Health Disorders:** | | | Limited Motion | | |
| **Alzheimer's** | | | Artificial Joint | | |
| | | | 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. Medications can only be dispensed to patient. 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