Platinum Weight Loss Center
Wellness & Aesthetics

Medical History

Are you under the care of a doctor for any medical conditions?

Please circle: Yes or No

If yes, then for what ? _____

Are you taking any medications or supplements at the present time?
Please circle: Yes or No
If yes then please list the medications:
_____
_____
_____
_____
_____

Any allergies to medications? Yes or No

If yes then what medications? _____

Any food allergies: _____

Medical Conditions: Please circle any that apply

Heart Attack Stroke Heart Rhythm Problem Heart Failure
Hypertension Emphysema Cancer Kidney Disease HIV
Ulcers Gallbladder Disease Liver Disease Tuberculosis
Thyroid Disease Active Ovarian Cysts Bleeding Disorder
Seizures Asthma Anemia Sickle Cell Thalassemia Hemophilia

Surgical History or Procedures: