

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:		
History of seizures, convulsions, epilepsy	Y	N
History of head trauma or brain tumor	Y	N
History of an eating disorder (anorexia, bulimia)	Y	N
History of depression	Y	N
Did you ever feel so bad you wanted to hurt yourself?	Y	N
Currently on Wellbutrin or Zyban?	Y	N
Previous adverse reaction to Wellbutrin or Zyban?	Y	N
Currently on MAO Inhibitor (Nardil, Parnate)	Y	N
Currently on medications that could increase seizures? (Anti- psychotics, Tricyclic Antidepressants, Theophylline, Ultram)	Y	N
Taking medication or insulin for diabetes?	Y	N
Using cocaine, stimulants, diet medications	Y	N
Drink alcohol	Y	N
Recent withdrawal from alcohol or benzodiazepines (Valium)	Y	N
Kidney or Liver Disease?	Y	N
Uncontrolled high blood pressure?	Y	N
Difficulty sleeping/insomnia	Y	N
Pregnant, planning on pregnancy, or breast-feeding	Y	N
Previous adverse reaction to nicotine replacement medications	Y	N
Dental or jaw problems	Y	N
Asthma	Y	N
Sinus problems or nasal problems (rhinitis, polyps)	Y	N

Are there any additional medical conditions we should be aware of? YES NO

If yes, please explain: _____

