

INTRAVENOUS (IV) INFUSION THERAPY INTAKE AND MEDICAL HISTORY FORM

| | | | |
|---------------------------------------|----------|---------------|-----|
| Name | | Date | |
| Address | | | |
| City | Province | Postal Code | |
| Phone: Home | Cell | Other | |
| Date of Birth (MM/DD/YY) | | Age | Sex |
| Occupation | | Email address | |
| In case of emergency, please contact: | | | |
| Name | | Phone | |

How did you hear about us? Internet Social Media Walk-in Friend or family: _____

What are your main complaints? (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Fatigue or low energy | <input type="checkbox"/> Weight gain or difficulty losing weight | <input type="checkbox"/> Facial wrinkles or fine lines |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Slow metabolism | <input type="checkbox"/> Dull or dry skin |
| <input type="checkbox"/> Poor diet due to busy lifestyle | <input type="checkbox"/> Asthma and Allergies | <input type="checkbox"/> Skin hyperpigmentation (i.e. melasma) |
| <input type="checkbox"/> Brain fog or trouble concentrating | <input type="checkbox"/> Recent surgical procedure | <input type="checkbox"/> Malabsorption issues |
| <input type="checkbox"/> Low mood or depression | <input type="checkbox"/> Recent illness | <input type="checkbox"/> Other – specify _____ |
| <input type="checkbox"/> Headaches or migraines | <input type="checkbox"/> Cold or flu symptoms | |

Name of Personal Physician _____

Phone Number _____

Date of Last Office Visit _____

Have you had laboratory testing or blood within the last year? YES NO

Date of last laboratory testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? YES NO

Please check all that apply:

- Hypermagnesemia (High magnesium levels)
- Hypercalcemia (High calcium levels)
- Hypokalemia (Low potassium levels)
- Hemochromatosis or hemosiderosis (High iron levels)
- Other – specify _____

Have you had an IV before? YES NO

Are you pregnant or breastfeeding? YES NO

Initials _____

Please use extra paper as needed

Do you have any of the following conditions? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Blood pressure problems (high or low) | <input type="checkbox"/> Pleural Effusions |
| <input type="checkbox"/> Heart Problems or Heart Failure | <input type="checkbox"/> Optic Nerve Atrophy or Leber's Disease |
| <input type="checkbox"/> Previous Heart Attack | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Stroke or "mini-stroke" | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Bleeding problems, Hemophilia or von Willebrand Disease | <input type="checkbox"/> Parathyroid problems (High levels) |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Allergies to drugs – if YES, specify _____ |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Allergies to foods – if YES, specify _____ |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Allergies to chemicals – if YES, specify _____ |
| <input type="checkbox"/> Lung Conditions | <input type="checkbox"/> Allergies to supplements – if YES, specify _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergic to sulpha, sulphites, sulphur? – if YES, specify _____ |

****Please check here if you attest to having none of the above***

If you have an allergic reaction to any of the above, please give details _____

List any other medical conditions you have (not mentioned above) _____

Are you a diabetic? YES NO If YES, is your diabetes under control? YES NO

Are you a smoker? YES NO

If YES, how much do you smoke per day? _____ How many years? _____

How many alcoholic drinks do you consume in a week? _____

Do you use any recreational drugs? YES NO If YES, which ones and how often? _____

Have you ever fainted? YES NO If YES, please give details _____

Check any of the following that you are currently taking:

- () Laxatives () Cortisone () Tranquilizers () Thyroid Medication () Diet Pills
() Pain Relievers () Appetite suppressants () Antacids () Antibiotics () Dioxin
() Steroids () Diuretics (e.g. HCTZ, Lasix) () Aspirin or other blood thinner medications

OVER THE COUNTER DRUGS – Name – Strength – Frequency – Condition being treated

VITAMINS AND OTHER SUPPLEMENTS – Name – Strength – Frequency – Condition being treated

Is there anything else you would like our medical staff to know about you or your health concerns?

I affirm that I have answered the above questions and statements truthfully and to the best of my knowledge.

Patient's Signature _____ Date _____