



Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better? \_\_\_\_\_

Allergies (Medications, foods, etc.): \_\_\_\_\_

Current Medications: (Please include OTC & supplements): \_\_\_\_\_

Please check any conditions that apply to you:

### CARDIOVASCULAR AND RESPIRATORY

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abnormal Rhythm           | <input type="checkbox"/> Valve Disorder                   | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Cardiac Surgery or Stents | <input type="checkbox"/> Aneurysm                         | <input type="checkbox"/> COPD                          |
| <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> Peripheral Artery Disease        | <input type="checkbox"/> Lung Cancer                   |
| <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> Thrombosis or DVT                | <input type="checkbox"/> Pulmonary Hypertension        |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Other Cardiac Disorder:<br>_____ | <input type="checkbox"/> Shortness of Breath           |
| <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Sleep Apnea                      | <input type="checkbox"/> Other Lung Disorder:<br>_____ |
| <input type="checkbox"/> High Blood Pressure       |   |  |

### GASTROINTESTINAL AND URINARY

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acid Reflux     | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Other<br>_____ |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Kidney Disease    |   |
|  | <input type="checkbox"/> Liver Disease     |   |

### METABOLIC/ENDOCRINE/AUTOIMMUNE

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes Type I Type II | <input type="checkbox"/> Lupus                | <input type="checkbox"/> Other<br>_____ |
| <input type="checkbox"/> Hx of DKA               | <input type="checkbox"/> Rheumatoid Arthritis |   |
| <input type="checkbox"/> Hyper/Hypo Thyroid      |   |   |

### NEUROLOGIC

- |   |                                      |   |
|---|--------------------------------------|---|
| <input type="checkbox"/> Alzheimer's        | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Seizures – date of last seizure ____/____/____ |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke/TIA  |   |

