**Medical Questionnaire for Intravenous Therapy Patients:**

**Allergies:** Please list anything you are allergic to (medications, food, etc.). If none, please write "None."

1) ________________________     3) ________________________     5) ________________________
2) ________________________     4) ________________________     6) ________________________

**Medications (prescription items):** Name of Prescriptions, Strength and Frequency

1) ______________________________________     6) ______________________________________
2) ______________________________________     7) ______________________________________
3) ______________________________________     8) ______________________________________
4) ______________________________________     9) ______________________________________
5) ______________________________________    10) ______________________________________

**Medical History:** Please **Circle** pertinent medical history and **List** additional medical problems

1) - Diabetes Mellitus Type I - Diabetes Mellitus Type II (Adult Onset) - Hypo Hypothyroidism
   - Asthma - COPD/Emphysema - Hypertension
   - Congestive heart failure - Coronary artery disease/Chest pain - History of Heart Attack
   - Shortness of breath - Edema (arm or leg swelling) - Chronic nausea/Vomiting
   - Liver problem - Kidney problem including kidney stones - Hepatitis B or C positive
   - Constipation/Diarrhea - Inflammatory Bowel Disease - Irritable bowel syndrome
   - History of Stroke - History of blood clot or DVT - Enlarged Prostate

- Any type of Cancers (Please specify type of cancer) - ________________________________

2) **Please list any additional medical problems:**

a) ____________________________________     e) ____________________________________

b) ____________________________________     f) ____________________________________

c) ____________________________________     g) ____________________________________

d) ____________________________________     h) ____________________________________
**Surgical History:** Please Circle pertinent surgical procedures and List any additional surgeries

1) - Brain surgery (Tumor resection/Shunt placement)
- Cataract surgery
- Gall bladder surgery
- Joint surgery
- C-section

- Tonsillectomy
- Appendectomy
- Hernia surgery
- Mastectomy

- Angioplasty/Heart Bypass
- Joint replacement surgery
- Hysterectomy (complete/partial)
- Prostate surgery

2) Please list any additional surgeries:

a) __________________________

d) __________________________

b) __________________________

e) __________________________

c) __________________________

f) __________________________

**Review of Systems:** Please Circle symptoms you are experiencing. These symptoms are pertinent to patients receiving intravenous therapy.

**General:** Weakness / Fatigue / Dehydrated / Fever / Chills

**Head and Neck:** Headache / Dizziness / Sinus pain and discharge / Sore throat / Ear pain

**Pulmonary:** Coughing / Wheezing / Sputum production / Shortness of Breath / Coughing up blood

**Cardiovascular:** Chest pain / Shortness of breath with exertion / Arm or Leg swelling / Trouble breathing when lying down flat / Leg pain (muscles) when walking / History of heart disease / History of heart failure / Heart Murmur

**Gastrointestinal:** Nausea / Vomiting / Abdominal enlargement / Abdominal pain / Rectal bleeding / Constipation or diarrhea / Previous Jaundice / History of Liver failure / Ascitis

**Genitourinary:** Incontinence / Problem with prostate / Pain with urination / Frequency of Urination / Blood in the urine

**Neurological:** Fainting / Seizures / Abnormal gait / Paralysis

**Endocrine:** Goiter or thyroid trouble / Diabetes / Increased thirst / Frequent urination

**Blood / Lymphatic:** Anemia / Bleeding tendency / Clotting Problems / Enlarged Lymph node / Easy bruising

**Musculoskeletal:** Muscle cramps / Muscle weakness / Pain in the joints / Swollen joints