Name:_____________________________________ **Date of Birth:**_______________________

Address:___________________________________ **Email:**_____________________________

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 Hyperthyroidism
- 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	- Tonsillectomy	- Angioplasty/Heart Bypass
- Gall bladder surgery	- Appendectomy	- Joint replacement surgery
- Joint surgery	- Hernia surgery	- Hysterectomy (complete/partial)
- C-section	- Mastectomy	- 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

Signature:________________________________ **Date:**____________________