IV PATIENT HISTORY FORM

Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____
Last First M. I.

Age: __________ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen

PCP:

Specialists:

CURRENT MEDICATIONS		
Drug allergies: ❑ No ❑ Yes To list?		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Providers initials _______

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PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

____

____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

Providers initials _______

IV PATIENT HISTORY FORM

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

WOMENS REPRODUCTIVE HISTORY:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

Providers initials _______

I, ______________________________ DOB ___/___/___ , hereby authorize the following procedure: administration of intravenous vitamins, minerals, and other nutrients.

Products and Services

- We are providing IV and injection vitamin boosts. Vitamins and minerals are essential for the cells to function properly.
- Vitamin boosts and infusions are the fastest, most efficient way for your body to receive hydration and micronutrients.
- These essential nutrients are delivered in to the bloodstream where your cells can begin to uptake what your body needs right away.

This document is intended to serve as confirmation of informed consent for IV therapy and boost
(_____) I have informed the physician of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to anesthetics.

(_____) I have informed the doctor of all current medications and supplements.
I understand that I have the right to be informed during the procedure, and the risks and benefits.

Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

- The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids).

- I understand that risks, benefits and alternatives to IVs may include but are not limited to:

1. **The Risks and potential side effects**
o Discomfort, bruising, and pain at the site of injection.
o Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
o Severe reaction, anaphylaxis, cardiac arrest, or death.

2. **The Benefits**
o Injectables are not affected by stomach or intestinal disease.
o Total amount of infusion enters the bloodstream and is available to the tissues
o Higher doses of nutrients can be given by vein than by mouth without intestinal irritation that can accompany doses given by mouth.
o IV chelation therapy helps to reduce and eliminate heavy metals.

3. Alternatives to intravenous vitamin therapy are oral supplementation and/or dietary and lifestyle changes.

4. I am aware that other unforeseeable complications could occur. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered. I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance.

5. My signature on this form affirms that I have given my consent to IV therapy with any different or further procedure, which in the opinion of my physician(s) or other(s) associated with this practice, may be indicated.

6. I understand the information provided on this form and agree to the foregoing. I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedures) set forth above has been adequately explained to me by my physician. I understand that I am free to withdraw my consent and to discontinue participation in their treatments at any time. I understand that, except in emergencies, I must give

The **principal side effects** that may accompany intravenous administration of nutrients include:

- -burning and stinging at the site of infusion or if IV infiltrates into surrounding tissue
- -muscular spasms, weakness, or fatigue
- -allergic reactions (rare)
- -local thrombophlebitis (very rare).

Based on the risks and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment from the Nurse Practitioners at Anthem Pain Management, LLC, as is appropriate and necessary for my care.

I hereby place myself under your care for intravenous vitamin therapy and agree to the above release. I also verify that all information presented to medical provider in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my Insurance **will not** be billed for IV treatments. I agree to be responsible for payment at the time of service for all services.

My signature below confirms that:
1. I have received all the information and explanation I desire concerning the procedure.
2. I authorize and consent to the performance of the procedure(s)

__________________________________ **DOB ___/___/___**

Print Patient Name

PATIENT SIGNATURE DATE

Witness

Medical Provider DATE