Intravene

PATIENT INFORMATION

Patient's Name:_____

Home Address: _____City:_____State:_____Zip: _____

Alternate Address:_____City:_____State:_____Zip:_____

Home Telephone:_____ Cell Phone:_____ Work Phone:_____

Date of Birth:_____ Age:_____ SSN_____-_____-_____

Email Address (optional):_____

Height:_____Current Weight:_____Usual Weight_____ Have you had a recent weight gain or loss: Yes or No

INSURANCE INFORMATION ****Please attach card to clipboard for copying**

Primary Ins:_____ Policy #_____ Group#_____

Insured Name:_____ Insured Date of Birth:_____

Insured Employer:_____ Employer Phone number:_____

Secondary Ins. (if applicable):_____Policy #_____ Group#_____

Insured Name:_____ Insured Date of Birth:_____

Insured Employer:_____ Employer Phone number:_____

DRUG ALLERGIES *Please list any current or past reactions.* _____I DO NOT have any drug allergies.

Allergy to (drug, latex, shellfish, iodine)	Reactions (itching, coughing, hives, etc)

MEDICATIONS *Please list all medications you take* ***with or without a prescription*** *(use additional paper if needed).*

Medication Name	Dosage/# per day

MEDICAL HISTORY *Please check if you have ever been diagnosed with the following:*

- ☐ Angina
- ☐ Anxiety/Panic Attacks
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots, where:_____
- ☐ Bronchitis
- ☐ Cancer. Type:_____
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ GERD (Reflux)
- ☐ Gallbladder Disease
- ☐ Gout
- ☐ Heart Attack,
- ☐ Hemophilia/Bleeding Disorder
- ☐ Hepatitis A / B / C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines
- ☐ MRSA
- ☐ Osteoarthritis
- ☐ Osteomyelitis (bone infection)
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other Heart Disease
- ☐ Rheumatic Fever
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Stomach Ulcers
- ☐ Stroke

†

Are there any other medical problems we should know about? _____

SOCIAL HISTORY

Do you live alone? Yes or No If no, with whom do you live?_____

Do you use tobacco? Yes or No If yes, what product and how long?_____

Do you drink alcohol products? Yes or No If yes, what and how often?_____

Do you use recreational drugs? Yes or No

SURGERIES or PROCEDURES *(use additional paper if needed)* _____I HAVE NOT HAD any surgeries.

Surgery (describe type)	Year