IV Therapy Intake Form/ Good Faith Assessment

Patient Name: _____ Birthdate: _____ Date: _____

Primary Care Physician: _____

Current health conditions:

_____

_____

Current medications:

_____

_____

Date of last blood test/physical exam: _____

Past medical history (check all that apply):

Hypertension _____ Angina _____ Ankle swelling _____

Arrhythmia ____ CHF _____ Heart attack _____

Abnormal EKG _____ Kidney Disease _____ Generalized edema _____

Bleeding disorder _____ Asthma _____ Pulmonary edema _____

Sudden weight loss _____ Diabetes _____ Anxiety or panic attacks _____

G6PD deficiency _____ Cancer _____

Give pertinent details of conditions listed above:

_____

_____

Medication, food, or other allergies:

_____

Allergic reactions if allergies listed above (please explain):

_____

Are you currently pregnant? _____ Are you breastfeeding? _____