Infusion
WELLNESS CENTER

History and Physical Form

Date

Name: _____ Date of Birth: _____ Sex: _____

Allergies_____

Current Medications:_____

Have you ever had a nutrient IV infusion?

No____ Yes (when and what)_____

Problems with prior infusions including reactions, allergies or access issues?

_____

What condition are you looking to address and/or what is your wellness goal?

Do you have any of the following conditions?

- [ ] None
- [ ] End Stage Renal Disease
- [ ] Myasthenia Gravis
- [ ] Myxedema
- [ ] Cerebral Hemorrhage
- [ ] HyPERmagnesium
- [ ] Current UTI
- [ ] HyPERparathyroidism
- [ ] Kidney/Renal Disease
- [ ] Cardiac Arrhythmia
- [ ] G6PD Deficiency
- [ ] Hemolytic Anemia
- [ ] Low Blood Pressure

Have you been told that you need to start dialysis or are you currently on dialysis?	Yes	No
Are you taking or have you been told you need to take Digoxin?	Yes	No
Are you of African, Middle Eastern or Asian descent?	Yes	No
Have you been told you have a decreased GFR or kidney problem?	Yes	No

If Yes, please explain_____

I have personally reviewed and completed this entire document and the information I provided herein is true and accurate.

Patient's Printed Name_____ Date_____

Patient's Signature_____

Infusion Wellness Center

History and Physical Form

Date

For Clinic Use Only

Physical Exam

General Appearance:

Integumentary System:

Head and Neck:

Cardiovascular System:

Respiratory System:

Gastrointestinal System:

Musculoskeletal System:

Neurological System:

Extremities:

Other (specify):

Physical Exam Findings (if outside normal parameters)

Practitioner's Name_____ Date_____

Practitioner Signature_____