IV/IM HYDRATION HEALTH INFORMATION FORM

NAME:_____ Date:_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

EMAIL:_____ PHONE:_____

HOW DID YOU HEAR ABOUT US:_____

LIST ANY CONDITION YOU ARE CURRENTLY BEING TREATED FOR OR HAVE A HISTORY OF:

_____

_____

Do you have: LIDOCAINE ALLERGY ANAPHYLAXIS _____ yes or no

MEDICATION ALLERGIES: _____

MEDICATIONS: PLEASE INCLUDE TOPICAL, OVER THE COUNTER, HEBAL/HOLISTIC REMEDIES & SUPPLEMENTS AND PRESCRIPTIONS:

_____

_____

_____

FOR FEMALE PATIENTS:

Are you currently pregnant or plan to become pregnant: ____ Are you currently lactating? _____

Do you use birth control? _____ Last menstrual cycle**: _____**

_____ _____ _____

Patient Signature **Clinician Signature** **Date**

Notes:_____