Dr. Balwinder Badhan, ND

IV THERAPY PATIENT INTAKE FORM

Patient Name: (Last)_____(First)_____(MI)_____

Patient Address:

_____

City: _____State: _____ Zip Code: _____

PhoneNumber:_____Email:_____
Birthdate:_____ Age:_____ Sex: -M F

In Case of Emergency:

Name: _____Relationship: _____Phone: _____

Family Physician: _____Phone: _____

Referred By: _____Phone: _____

Current concerns----------

Allergies: Do you have any allergies to any medications/foods/supplements? Yes/No

If yes, please describe the type of medication/foods/supplements:

Present medical conditions ----------

Past Medical History (-please check if you have had any of the following):

-Tuberculosis, -Measles, -Influenza, -Mumps, -Diphtheria, -Rheumatic, -Fever German Measles (3 day), -Scarlatina, -Polio, -Whopping Cough, -Frequent Colds, -Tonsillitis, -Chickenpox, -Scarlet Fever, -Pneumonia

- Heart disease /Angina-Diabetes (Type): _____ -Hypertension, – Arrhythmia ,

-- Abnormal EKG, – CHF, – MI, – Ankle swelling, – Generalised swelling, -- Kidney dz, -- Asthma,

-- Pulmonary Edema, -- Bleeding disorder, -- Sudden weight loss, --DM, --Anxiety/panic attack, --fainting,

--fear of needles/blood, -- Are you pregnant, --G6PD deficiency, --Allergic reaction (specific),

-Cancer, Type: _____, ---Anaphylaxis

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Pertinent details of conditions checked above----------

Medications: What kind of medications are you currently taking? (please list name and strength:

What kind of supplements/vitamins are you currently taking?

TO BE FILLED BY IV TEAM:

Known Allergens----------

(Circle) if Allergic to ----------Latex----------Shellfish----------Iodine

When indicated:

Presence of edema----------Lung sounds----------
Heart sounds----------

Vital signs:

BP----------Pulse----------RR----------Temp----------

Notes----------

