IV Therapy Consent & Medical History Form

Patient Name:

Date of Birth:

Phone Number:

Email:

Emergency Contact

Name:

Relationship:

Phone:

Current Medications (include vitamins and supplements)

Past Medical History

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Asthma
- ☐ Respiratory / Lung Disease (COPD etc.)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Diabetes

Allergies

List any allergies:

Medical Screening

Have you been diagnosed with Congestive Heart Failure?	☐ Yes	☐ No
Do you have respiratory disease or chronic shortness of breath?	☐ Yes	☐ No
Do you have kidney disease or problems with fluid retention?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No

Consent

IV nutrient therapy involves the intravenous administration of fluids, vitamins, and nutrients.
Potential risks include bruising, infection, vein irritation, allergic reaction, or fluid overload.
I confirm the information provided is accurate and I voluntarily consent to IV therapy.

Patient Signature:

Date: