Intake Questionnaire

Luz Family Medical Practice and Wellness Center
580 5ht Street, Suite 500
Brookings, Oregon 97415
Telephone: 541-813-2101

Date: _____

Name: _____ DOB: _____ Age: _____

Address:

_____

_____

Phone: _____ Email: _____

Reason for visit:

_____

Emergency Contact:

_____

Please briefly describe why you are seeking IV infusion or injection therapy? For example: Are you looking to improve your energy, skin/hair/nail quality, recovery times, immune system, or hydration status? Are you seeking treatment for a hangover or looking to feel and look better?

_____

_____

_____

_____

_____

Allergies (Medications, foods, etc.):

_____

_____

_____

Current Medications: (Please include OTC & supplements)

_____

_____

_____

_____

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Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPIRATORY

High Blood Pressure
Heart Murmur
Valve Disorder
Abnormal Rhythm
Chest Pain
Heart Attack
Cardiac Surgery or Stents
Congestive Heart Failure
Peripheral Artery Disease
Thrombosis or DVT
Aneurysm

qAsthma
qCOPD
qSleep Apnea
qShortness of Breath
qPulmonary Hypertension
qLung Cancer
qOther Lung Disorder _____
Other Cardiac Disorder _____

GASTROINTESTINAL AND URINARY

Acid Reflux
Bladder Disease
Kidney Disease
qLiver Disease
qHepatitis A, B, C
qOther _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

Hyper/Hypo Thyroid
Diabetes Type I Type II
Lupus
qRheumatoid Arthritis
qHx of DKA
qOther _____

NEUROLOGIC

Stroke/TIA
Multiple Sclerosis
Seizures – date of last seizure _____
qParkinson's
qAlzheimer's

HEMATOLOGY

Anemia (Iron Deficiency, Pernicious, Aplastic, Hemolytic, Sickle Cell)
MTHFR
G6PD Deficiency

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MUSCULOSKELETAL

Back Pain qDegenerative Joint Disease
Carpal Tunnel Syndrome qDegenerative Disk Disease
Fibromyalgia qOther_____

PSYCHOLOGICAL

Depression
Anxiety or Panic Attacks
qSuicidal Ideations

CANCER

q Location of cancer _____
qChemotherapy
qRadiation

WOMEN (non-menopausal)

Last Menstrual Period _____ Any chance that you are pregnant? _____
Are you currently breastfeeding? _____

PAIN

qCRPS
qFibromyalgia

Do you drunk alcohol or abuse any types of drugs? If so, please explain:

_____
_____
_____

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?

_____
_____
_____
_____

Would you like to tell us anything else that you feel like is important?

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I attest that the information I have provided is true and accurate to the best of my knowledge:

Signature Date

Print name