Intake Questionnaire

Luz Family Medical Practice and Wellness Clinic
937 Chetco Ave Building D
Brookings, OR 97415
P: (541) 813-2101

LUZFAMILY
MEDICAL PRACTICE LLC

Date: _____

Name: _____ DOB: _____ Age: _____

Address:

_____

_____

Phone: _____ Email: _____

Emergency Contact:

_____

Reason for Visit:

_____

_____

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, ect.):

_____

_____

Current Medications (Please include OTC and supplements):

_____

_____

_____

_____

Please check any conditions that apply to you:

CARDIOVASCULAR AND RESPITATORY

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

Asthma
COPD
Sleep Apnea
Shortness of Breath
Pulmonary Hypertension
Lung Cancer
Other Lung Disorder: _____
Other Cardiac Discorder: _____

GASTROINTESTINAL AND URINARY

Acid Reflux
Bladder Disease
Kidney Disease

Liver Disease
Hepatitis A, B, C
Other: _____

METABOLIC/ENDOCRINE/AUTOIMMUNE

Hyer/Hypo Thyroid
Diabetes Type I or Type II
Lupus

Rheumatoid Arthritis
History of DKA
Other: _____

NEUROLIGIC

Stroke/TIA
Parkinson's
Alzheimer's
Multiple Sclerosis
Seizures Date of last seizure: _____

HEMATOLOGY

Anemia (iron deficiency, pernicious, aplastic, hemolytic, sickle cell)
MTHFR
G6PD Deficiency

MUSCULOSKELETAL

Back Pain
Carpal Tunnel Syndrome
Fibromyalgia
Degenerative Joint Disease
Degenerative Disk Disease
Other: _____

PSYCHOLOGICAL

Depression
Suicidal Ideations
Anxiety or Panic Attacks
Other: _____

CANCER

Location of cancer: _____
Chemotherapy
Radiation

WOMEN

Last menstrual Period: _____
Any chance that you are pregnant? YES NO
Are you breastfeeding? YES NO

PAIN

CRPS
Fibromyalgia

Do you drink 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?

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

Signature Date

Printed Name