Medical History Form for New Infusion Client

Today's Date: _____

Name: _____ Birthdate: _____
Phone: _____ Email Address:_____
Address: _____
Emergency Contact: _____ Relationship: _____
Phone (s): _____
Primary Care Physician: _____ Phone:_____

How did you hear about OW infusion services: _____

IV Nutrient Infusion Requested: _____
Have you ever had an **IV nutrient infusion** before: YES NO If yes, when and where: _____
_____
Problems with prior infusions including reactions, allergies, or IV access issues? _____
_____
(Females only) Currently having periods: YES NO If yes, date of last menstrual cycle: _____
Pregnant: YES NO

Focused Client History

Symptoms hoping to target with infusion:
_____
_____

Have you been told you have decreased GFR or a kidney problem? YES NO
Have you ever been screened for G6PD deficiency? YES NO
Do you have any of the following conditions? None

End Stage Renal Disease	Myasthenia Gravis	Cerebral Hemorrhage	Myxedema
HyPERmagnesium	Current UTI	HyPERparathyroidism	Kidney Disease
G6PD Deficiency	Hemolytic Anemia	Low Blood Pressure	

*Download, complete, and email form to **info@owforlife.com**

Optimal Wellness™ FOR LIFE

Medical History Form for New Infusion Client

Medical Diagnosis/Date of Onset:

Diagnosis	Date	Treatment

Surgeries & Hospitalizations:

Surgery	Date	Comments

Hospitalization	Date	Comments

Allergies:

Medication Allergy	Reaction
Environmental Allergy	**Reaction**
Food Allergy	**Reaction**

*Download, complete, and email form to **info@owforlife.com**

Optimal Wellness™ FOR LIFE

Medical History Form for New Infusion Client

Medications/Supplements:

Medication	Dose	Frequency	Indication
Supplement	**Dose**	**Frequency**	**Indication**

Social History:

Alcohol: Do you currently drink alcohol? Y/N Frequency: _____

Recreational Drugs: Current use: _____ History of use: _____

Tobacco Products: Current use: _____ History of use: _____
Please include nicotine use such as vaping and e-cigarettes or any other similar devices.

Occupation: _____ Marital Status: _____

Exercise: Practice: _____ Frequency/Duration: _____

Patient Signature: _____ Date: _____

*Download, complete, and email form to **info@owforlife.com**