IV Therapy Patient Intake

[COMPANYLOGO]

Patient First Name: *: _____ **Patient Last Name: *:** _____

D.O.B: *: _____ dd / mm / yyyy **Address: *:** _____

Zip Code: *: _____ **Contact Number: *:** _____

Email: *: _____ **Emergency Contact *:** _____

Emergency Contact Relationship: *: _____ **Emergency Contact number: *:** _____

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE

Have you previously received any aesthetic treatments (e.g. laser, peels, dermabrasion etc?)

◯ No ◯ Yes

If yes, please give more details:

Have you had any dermal filler treatment or botulinum toxin?

◯ No ◯ Yes

If yes, which treatment did you receive, what areas were treated and when?

Do you have any difficulty swallowing?

◯ No ◯ Yes

Are you currently receiving any medical treatment?

◯ No ◯ Yes

If yes, please give details:

Are you currently taking any dietary supplements or medications?

◯ No ◯ Yes

If yes, please note them below? (Include any steroids, aspirin, anticoagulants, antibiotics, over the counter or herbal medications)

Have you had previous surgery?

◯ No ◯ Yes

Do you have any problems with hormones, irregular periods?

○ No ○ Yes

Do you suffer from myasthenia gravis or Eaton Lambert syndrome?

○ No ○ Yes

Have you ever had a reaction to any brand of Botulinum toxin type A or dermal filler?

○ No ○ Yes

Have you suffered from any of the following?

- ☐ Heart disease/Angina
- ☐ Auto-immune disease
- ☐ Asthma/bronchitis
- ☐ Depression
- ☐ Facial cold sores
- ☐ Are you pregnant or breastfeeding
- ☐ Stomach ulcer/colitisSkin disease (e.g. eczema, herpes, acne)
- ☐ Glaucoma/cataract
- ☐ Bell's/facial palsy
- ☐ Hypoglycaemia
- ☐ Any adverse reaction to latex gloves
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Convulsions/epilepsy
- ☐ High/low blood pressure
- ☐ Headaches
- ☐ Diabetes
- ☐ HIV/Hepatitis
- ☐ Hypertrophic/lumpy scar healing
- ☐ Phlebitis
- ☐ Liver disease

Do you smoke?

○ No ○ Yes

If yes how many per day

If no, have you ever smoked?

○ No ○ Yes

If yes, when did you give up

Do you drink alcohol?

○ No ○ Yes

If yes, how many units per week?

Do you suffer from allergies/anaphylaxis?

○ No ○ Yes

If yes, please give details

Have you ever been admitted to Hospital?

◯ No ◯ Yes

If yes, please give details

If you have any questions about the above please discuss these with your practitioner. If the answer is yes to any of the above, your practitioner may ask for further details. Treatment may be refused if it is not considered in your best interest to proceed.