GynoFitMD
Women's Health & Medical Weight Loss Expert

Patient IV Therapy Intake Form

Patient Information

Full Name: _____

Date of Birth: _____ **Age:** _____ **Phone:** _____

Email: _____

Emergency Contact Name: _____ **Phone:** _____

Primary Care Physician: Phone: _____

Medical History

Have you ever been diagnosed with or currently have any of the following? (Check all that apply):

☐ High Blood Pressure ☐ Myasthenia Gravis ☐ Kidney Disease/Failure
☐ Bleeding/Clotting Disorders ☐ Heart Disease ☐ Arrhythmias
☐ Congestive Heart Failure ☐ Cardiomyopathy ☐ History of MI or CABG
☐ Other: _____

Are you currently pregnant? ☐ Yes ☐ No **Are you currently breastfeeding?** ☐ Yes ☐ No

Allergies

Have you ever had an allergic reaction to any of the following? (Check all that apply):

☐ Foods/Nuts ☐ Shellfish/Animal Protein ☐ Zofran
☐ Lidocaine ☐ Penicillin ☐ Sulfa
☐ Other Medications: _____

Current Medications & Supplements

Medication Name	Dose	Frequency	Taken For	Date Started

Authorization and Certification

I certify that the preceding medical, medication, and personal history information I have provided is true, complete, and accurate to the best of my knowledge. I understand that it is my responsibility to inform GynoFitMD of any changes to my health or medications prior to receiving IV therapy. I authorize GynoFitMD and its licensed medical staff to administer IV therapy as deemed appropriate and consent to treatment accordingly.

Signature: _____ **Date:** _____