ACTIVE infusions

NEW PATIENT MEDICAL INTAKE FORM

Name: _____ Date of Birth: _____ Today's Date: _____

Have you traveled outside of the country in the last 30 days? (*circle one*) **Y N** If yes when and where: _____
Have you had a fever, cough, sore throat, loss of taste or smell, chills, nausea or vomiting in the last 14 days? (*circle one*) **Y N**
If yes, describe: _____

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS ☐ NO MEDICATIONS

MEDICATIONS *(please list all)*	DOSE *(mg., pill, etc.,)*	TIMES PER DAY

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Allergies/Asthma			
Anemia/Blood Disorder			
Cancer (*type*: _____)			
Crohn's Disease/Ulcerative Colitis/Gastrointestinal Diseases			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (*type*:_____)			
Emphysema (COPD) or Lung Disease			
Epilepsy/Seizures			
Heart Disease			
Hepatitis (liver) Disease/Jaundice			
High Blood Pressure (hypertension)			
High Cholesterol			
Hypothyroidism/Endocrine Disorder			
Psoriasis/Eczema/Hives			
Renal (kidney) Disease/UTI (urinary tract infections)			
Migraine Headaches			
Stroke			
Parkinson's/Multiple Sclerosis			
Other:			
Other:			
Other:			

REVIEW OF SYSTEMS ✓Please Check All That Apply to You NOW.

CONSTITUTIONAL
- ☐ Appetite Change
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Changes

HEAD, EAR, NOSE & THROAT
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge or Pain
- ☐ Facial Numbness
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus
- ☐ Trouble Swallowing
- ☐ Voice Change

EYES
- ☐ Double Vision
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Sensitivity to Light
- ☐ Visual Disturbance

RESPIRATORY
- ☐ Chest Tightness
- ☐ Choking
- ☐ Coughing
- ☐ Shortness of Breath
- ☐ Spitting up Blood
- ☐ Wheezing

CARDIOVACULAR
- ☐ Chest Pain
- ☐ Irregular Heart Rate
- ☐ Leg Swelling
- ☐ Rapid Heart Rate
- ☐ Varicose Veins

BREAST
- ☐ Abnormal Changes
- ☐ Discharge
- ☐ Lumps
- ☐ Pain in Breast
- ☐ Tenderness

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Acid Reflux
- ☐ Black/Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excess Hunger
- ☐ Excess Thirst
- ☐ Excess Urination
- ☐ Loss of Hair

GENITURINARY
- ☐ Bladder Incontinence
- ☐ Blood in Urine
- ☐ Decreased Sex Drive
- ☐ Difficulty Urinating
- ☐ Flank Pain
- ☐ Genital Sores
- ☐ Increased Urination
- ☐ Menstrual Cycle Changes
- ☐ Nighttime Urination
- ☐ Painful Intercourse
- ☐ Painful Urination
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Pregnant or Possibly Pregnant
- ☐ Scrotal Swelling
- ☐ STD Exposure
- ☐ Testicular Pain
- ☐ Vaginal Discharge
- ☐ Vaginal Itching or Irritation
- ☐ Vaginal Odor
- ☐ Urine Decrease

MUSCULAR
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Neck Stiffness

SKIN
- ☐ Acne
- ☐ Changes to Lesions or Moles
- ☐ Color Changes
- ☐ Itching
- ☐ Rashes
- ☐ Skin Dryness
- ☐ Skin Lesions
- ☐ Wounds

ALLERGY & IMMUNOLOGY
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Frequent Illness
- ☐ Recent Vaccine (in the last 6 weeks)
- ☐ Seasonal Allergies

NEUROLOGICAL
- ☐ Dizziness
- ☐ Difficulty Concentrating
- ☐ Facial Asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Loss of Balance
- ☐ Memory Difficulties
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

HEMATOLOGIC & LYMPHATIC
- ☐ Bruises Frequently or Easily
- ☐ Clotting or Bleeding Disorders
- ☐ Enlarged Lymph Nodes

PSYCHIATRIC
- ☐ Agitation or Irritability
- ☐ Anxiety
- ☐ Behavioral Changes
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Depression
- ☐ Excessive Anger
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Mood Swings
- ☐ Self-Injury
- ☐ Sleep Disturbance or Changes
- ☐ Suicidal Ideas
- ☐ Emotional Abuse
- ☐ Physical Abuse
- ☐ Sexual Abuse

Date of Last Menstrual Cycle: __-___-___

Additional Symptoms or Changes Not Listed: _____

Patient Name: _____ Date of Birth: _____