New Patient Information

Personal Information

Full Name		Date of Birth		Date
Address	Street	City	State	Zip
Home phone		Cell phone	Carrier	
Work				
Email Address				
Gender: Male Female Non-binary Other				
Occupation		Employer		
Employer Address	Street	City	State	Zip
Primary Physician		MD Phone		

How did you hear about our Dripp IV Therapy?

Friend _____ Patient _____ Doctor _____

Staff Member _____ Yelp _____ Social Media_____

Other <PersonalInfo.ReferralDetail>_____

Emergency Contact

Name	
Relationship	
Emergency contact Phone	

What is the reason for your visit?	

Medical History

Height		Weight	

Have you or do you still have:	No	Yes	Description
Asthma			
Emphysema			
Have you or do you still have:	No	Yes	Description
High Blood Pressure			
Heart Trouble			
Hepatitis or Liver Trouble			
Kidney Trouble			
Diabetes			
Epilepsy or Seizures			
Stroke			
Problems scarring			
Psychiatric issues			
Others not listed			
	No	Yes	How much/many?
Do you smoke?			
Do you drink?			
Do you have children			

Family History

Do you have any blood relatives with any of the following:	No	Yes	Description
Cancer			
Bleeding tendency			
Leukemia			
Heart Disease			
High Blood Pressure			
Repeated Infections			
Chronic Lung disease			
Tuberculosis			
Asthma			
Severe allergies			
Kidney disease			
Arthritis			

Mental illness			
Epilepsy or Seizures			
Migraine Headaches			
Diabetes			
Gout			
Thyroid Trouble			
Obesity			

Medications

Please list all medication, vitamins or herbal supplements you take:

Allergies	**No**	**Yes**
Are you allergic to any medications or local anesthetics?		

List:

I have completed this questionnaire to the best of my knowledge

Name	
Signature	
Date	