FUSIONDRIP
HYDRATION & WELLNESS

Patient Information for Antibiotics/Biologic Infusions

1. **Full name:** _____
2. **Date of birth:** _____
3. **Gender:** ☐ M ☐ F
4. **Phone Number: Cell**_____ **Home**_____
5. **Email address:** _____
6. **Address:** _____
7. **Name and telephone number of the emergency contact:**
   _____
8. **Preferred Pharmacy:** _____

Medical history

1. **Have you had a fever, infections (urine/sinusitis), or new wounds in the past 14 days?** ☐ Yes ☐ No
   If yes, please explain
   _____
2. **Primary Care Physician:** _____
3. **Date of last visit:** _____
4. **Current diagnoses:** _____
5. **Past surgeries (with dates):** _____
6. **Allergies (medications, food, etc.):** _____
7. **Are you pregnant, breastfeeding, or using birth control?** ☐ Yes ☐ No
8. **Do you smoke?** ☐ Yes ☐ No
9. **Do you consume alcohol?** ☐ Yes ☐ No
10. **Do you use recreational drugs?** ☐ Yes ☐ No
11. **Do you use a tanning bed or increase sun exposure?** ☐ Yes ☐ No If yes, how often

Present/Past Medical History Questionnaire

Please check all conditions that apply and provide additional details where necessary.

Medical conditions (past or present)

Condition	Yes	No
Asthma	☐	☐
Autoimmune disorder	☐	☐
Two-point problems	☐	☐
Excessive scarring	☐	☐
Heart valve disease	☐	☐
High/low blood pressure	☐	☐
Hormonal imbalance	☐	☐
Nephropathy	☐	☐
Muscular dystrophy	☐	☐
Thyroid disorder	☐	☐
Cancer (Type: _____)	☐	☐
Other: _____	☐	☐

Medical symptoms in the past 12 months

	Yes	No
Arthritis	☐	☐
Blood disorder	☐	☐
Diabetes	☐	☐
Excessive bleeding	☐	☐
Heart valve replacement	☐	☐
Hepatitis	☐	☐
Arrhythmia	☐	☐
Liver disease	☐	☐
Seizures	☐	☐

	Yes	No
Anemia	☐	☐
Bleeding disorder	☐	☐
Easy bruising	☐	☐
Infarct	☐	☐
Heart failure	☐	☐
HIV/AIDS	☐	☐
Intestinal problems	☐	☐
Lung disease	☐	☐
Blow	☐	☐

🚨 Symptom check (by body system)

Digestive

1. ☐ Nausea or vomiting
2. ☐ Diarrhea
3. ☐ Constipation or bloating
4. ☐ Belching / Passing gas
5. ☐ Heartburn
6. ☐ Other: _____

Head

1. ☐ Headaches/migraines
2. ☐ Faintness
3. ☐ Dizziness
4. ☐ Insomnia
5. ☐ Other: _____

Mouth/Throat

1. ☐ Chronic cough
2. ☐ Arcades
3. ☐ Need to clear your throat
4. ☐ Sore throat / Hoarseness / Loss of voice
5. ☐ Other: _____

Ears

1. ☐ Itchy ears
2. ☐ Earaches/infections
3. ☐ Drainage
4. ☐ Ringing/Hearing loss
5. ☐ Other: _____

Heart

1. ☐ Arrhythmia
2. ☐ Chest pain
3. ☐ Other: _____

Nose

1. ☐ Sinus problems
2. ☐ Other: _____

Eyes

1. ☐ Watery/itchy eyes
2. ☐ Blurred vision
3. ☐ Other: _____

Lungs

1. ☐ Shortness of breath
2. ☐ Congestion
3. ☐ Other: _____

Weight

1. ☐ Binge eating/drinking
2. ☐ Overweight / Underweight
3. ☐ Other: _____

Energy and activity

1. ☐ Fatigue
2. ☐ Hyperactivity
3. ☐ Other: _____

Skin and emotions

1. ☐ Acne
2. ☐ Mood Swings
3. ☐ Hives / Rashes / Dry skin
4. ☐ Anxiety/Depression
5. ☐ Other: _____

Medications and Supplements

List all current medications, including:

1. **Prescription Medications:** _____
2. **Over-the-counter medications:** _____
3. **Vitamins/Supplements:** _____

History of Infusion Therapy

1. Have you had IV therapy before? ☐ Yes ☐ No
2. If so, what type and when? _____
3. Any adverse reactions to previous infusions? _____
4. Have you failed any infusion medications? _____

Recent lab work

1. Date of last blood test: _____
2. Any abnormal lab results? (e.g., electrolyte imbalances, anemia): _____

Consent and Acknowledgment

By signing below, I confirm that:

1. I have disclosed all relevant medical history and current medications.
2. I understand the risks and benefits of infusion therapy.
3. I consent to receive the treatment recommended by the clinic's licensed professionals.

Signature: _____
Date: _____