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Intravenous (IV) Therapy – Patient Questionnaire

1. **Personal Information:**
   - Name: _____
   - Age: _____
   - Gender: _____
   - Contact No.: _____
   - Email Address: _____

2. **Medical History:**
   - Do you have any existing medical conditions? If yes, please specify.

     _____
   - Are you currently taking any medications or supplements? If yes, please list them.

     _____
   - Have you ever had an adverse reaction to IV therapy or any medications in the past?

     _____

3. **Lifestyle and Habits:**
   - Do you smoke? If yes, how many cigarettes per day?

     _____
   - How often do you consume alcohol?

     _____
   - Do you follow any specific dietary restrictions or preferences?

     _____

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4. **Symptoms and Goals:**

- What symptoms or conditions are you seeking treatment for?

  _____

- What specific outcomes or improvements are you hoping to achieve through IV therapy?

  _____

5. **Additional Information:**

- Have you had IV therapy before? If yes, please describe your experience.

  _____

- Is there anything else you would like us to know before your IV therapy session?

  _____

This questionnaire will help us ensure your safety and tailor the IV therapy session to meet your specific needs and goals. Thank you for providing this information.

Signed at _____ on this _____ day of _____ 2024.

Signature: _____