MedFit
IV Therapy & Weight Loss

Patient Form

Name: _____ DOB:_____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

How did you hear about us? (if referral please list name) _____

What brings you to the office today? _____

How does this concern/issue affect your daily life? _____

What makes these symptoms better or worse? _____

Please list any Conditions/Disease below as well as medications used for treatment.

Condition/Disease	Medication/Treatment

Please list any other medication/supplements you are taking: _____
_____

_____

Please list any **drug or food allergies**: _____

Do you tolerate B12 well? _____

Have you ever had any of the following conditions (circle ALL \that apply):

- Cancer of any kind _____
- Thyroid Disease
- HIV/AIDS
- Hepatitis/Liver Disease
- Heart Disease/Heart Attack/Myocardial Infarction
- High/Low Blood Pressure
- Hysterectomy
- Severe Headaches
- Hx of Depression/Anxiety
- Hx of Suicidality

Please list any significant **FAMILY** medical history including **FAMILY HISTORY OF THYROID CANCER:** _____

Please rate each of the following from 1 - 10 (1 being the worst/bad and 10 being the highest/excellent)

Fatigue _____ Stress _____ Body aches _____

Sexual Health _____ Overall Well Being _____ Confidence _____

Sleep Quality _____ Energy Level _____ Digestive Health _____

Answer the following

Tobacco Use (Packs/Day): _____ Alcohol Use (Drinks/Day/Week) _____

Caffeine Use: _____ Hours of sleep/night? _____

Circle the one that best describes your activity level: Sedentary/Moderate/Daily/Heavy

Briefly describe your exercise habits: _____

Briefly describe your diet: _____

List your personal health and wellness goals:_____

System Review: Please rate each symptom based upon your experiences over the last 60 days. 0 = No Symptoms 1 = Mild Symptoms 2 = Moderate Symptoms 3 = Severe Symptoms.

HEAD: Headache 0 1 2 3 Dizziness 0 1 2 3 Brain Fog 0 1 2 3 Migraines 0 1 2 3
EENT: Stuffy Nose 0 1 2 3 Congestion 0 1 2 3 Cough 0 1 2 3 Wheezing 0 1 2 3
EARS: Ear Infections 0 1 2 3 Ringing 0 1 2 3 Hearing loss 0 1 2 3
HEART: Elevated BP 0 1 2 3 Palpitations 0 1 2 3 Irregular Beat 0 1 2 3 Chest Pain 0 1 2 3
MUSCULOSKELETAL:
Joint Pain 0 1 2 3 Balance 0 1 2 3 Tendonitis 0 1 2 3 Back Pain 0 1 2 3
Sprains/Strains 0 1 2 3 Strength 0 1 2 3
NEUROENDOCRINE: I
Increased Thirst 0 1 2 3 Loss of Hair 0 1 2 3 Increased Urination 0 1 2 3 Low Libido 0 1 2 3
Restlessness 0 1 2 3 Lethargy 0 1 2 3 Sleeping Difficulty 0 1 2 3 Hunger Issues 0 1 2 3
Low Energy 0 1 2 3 Low Body Temp 0 1 2 3 Sweating 0 1 2 3
SKIN DISORDERS:
Itching 0 1 2 3 Wounds 0 1 2 3 Acne 0 1 2 3 Rash 0 1 2 3
Psoriasis 01 2 3 Eczema 0 1 2 3
METAL/EMOTIONAL:
Mood Swings 0 1 2 3 Irritability 0 1 2 3 Suicidal Ideation 0 1 2 3 Anxiety 0 1 2 3
Depression 0 1 2 3 Stress 0 1 2 3 Emotional Outbursts 0 1 2 3
WEIGHT:
Difficulty Losing Weight 0 1 2 3 Excessive Hunger 0 1 2 3 Abdominal Weight 0 1 2 3
GI: Abdominal Pain 0 1 2 3 Excessive Gas 0 1 2 3 Heartburn 0 1 2 3 Constipation 0 1 2 3
Diarrhea 0 1 2 3
GU: Problems urinating 0 1 2 3 Blood in Urine 0 1 2 3 Irregular Cycle 01 2 3
Vaginal Dryness 0 1 2 3 Yeast Infections 0 1 2 3 UTIs 0 1 2 3

I _____ (patient name), have read and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I authorize the healthcare provider, nurse, medical assistants, and any other deemed medical staff to administer treatments and medications as they deem necessary and advisable including recommending/ordering laboratory and other diagnostic tests as indicated for my medical concerns. I understand that by identifying my health risk factors, Medfit of Georgia will then recommend targeted lifestyle support that, if acted upon, can help me reduce my risk of disease and increase my ability to be healthier.I understand I have the right to refuse and treatment recommendation. I understand your office does not replace my primary care provider.

While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that any recommendations made are up to me to choose to accept and engage in for optimal results to occur.

I understand that if I withhold information or provide misinformation, incomplete results or

recommendations can occur from treatments received. I am aware that it is my responsibility to inform you of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Medfit of Georgia from liability and assume full responsibility thereof.

Patient Signature: _____ Date:_____