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**Patient Health Questionnaire**

**PATIENT INFORMATION: EMERGENCY INFORMATION:**

Patient/Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

New Pt - Est Pt – Room\_\_\_\_\_\_\_

Vitals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Hx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

N / V / F / Ch / D

Dehydrated? Yes No

Distress? Yes No AAOx3? Yes No

Mucosa: Mildly dry / Moderately dry / Severely dry

**Diagnosis:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

Current Weight: \_\_\_\_\_\_\_\_\_\_ (pounds)

Do you have Congestive Heart Failure (CHF)? Yes No

Do you have liver problems? Yes No

Do you have any kidney conditions? Yes No

Are you pregnant? Yes No

-if Pregnant, what medicines do you take for nausea?

**ALLERGIES to any of the following?**

Latex? Yes No

Vitamin A? Yes No

B Vitamins including Thiamine, Folate, and B12? Yes No

Vitamin C? Yes No

Magnesium? Yes No

Toradol (an NSAID like Ibuprofen, Aleve, Motrin)? Yes No

Zofran (nausea medication)? Yes No

List all drug allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:**

**Are you on any medications that warn of developing Serotonin Syndrome?** Yes No

(a list of such meds can be found at www.merckmanuals.com/professional/multimedia/table/drugs-that-can-cause-serotonin-syndrome**)**

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**HydraMed Infusion and Wellness - IV Therapy Consent From**

I hereby request and voluntarily consent to treatment with IV therapies of fluids, vitamins, micronutrients, and/or medications and placement of peripheral intravenous (IV) catheter. As with drugs and nutritional supplements, I understand that IV therapy may exhibit some side effects in certain sensitive individuals, may interact with certain medications or lab tests, or effect certain pre-existing disease conditions.

I agree to the following, and have had an opportunity to discuss with the physician/provider:

Prior to treatment:

* I will inform the physician/provider or staff of any allergies to any medications or materials
* I will inform the physician/provider or staff if I am pregnant, have kidney failure or liver disease, have congestive heart failure (CHF), etc.

I understand that in the practice of IV therapy there are some potential risks treatment, or attempted treatment, and that the following possible complications could occur, although they are very unlikely:

* Bruising at the site of catheter insertion. If this occurs, it should resolve within a week.
* Slight bleeding at insertion site.
* Low risk for potential infection. Infection can occur at the site of needle catheter; however only sterile materials are used which minimize such risk.
* Allergic reaction to a medication or other supplies. In the event of an allergic reaction, immediate therapeutic interventions will follow to stop a reaction.
* Potential of warm/burning sensation at the site of needle or in the vein through which therapy is being administered. This is a normal feeling when magnesium is used but if you are in discomfort or distress, let staff know immediately.
* Potential to feel dizziness, faint, or changes in blood pressure and blood sugar (though we do not use dextrose sugar in our fluids) during or following your treatment. Inform us immediately if you feel any of these symptoms.
* Other rare, but potential side effects include but are not limited to: fever, nausea, edema/swelling, “blown vein”, upset stomach, difficulty breathing, changes in heart rhythm, stroke, infection of the blood vessel, heart, or heart valves, allergic reaction including hives or anaphylactic shock, Serotonin Syndrome.

I recognize that the physician/provider and staff who practice at HydraMed Wellness and HydraMed-Mobile are licensed professionals consisting of Physician(s), Nurse Practitioners, and Physician Assistants who use the assistance of Registered Nurses, Licensed Practical Nurses, Paramedics, and/or EMT’s. Any questions relating to my care will be directly discussed with the provider(s) or relayed to the provider(s). The patient signing below understands that certain procedures and treatment and results vary from patient to patient. HydraMed and HydraMed-Mobile is not responsible for the negligence of any physician or staff rendering services and treatment at any of the HydraMed facilities.

HydraMed physician/provider and staff reserve the right to withhold treatment, in part or in whole, in good faith for the safety of the patient and/or physician/provider or staff.

**I HAVE READ AND UNDERSTAND THE ABOVE.** Under the conditions indicated, I hereby place myself under the care of Dr. John W. Tole and the providers and staff of HydraMed and/or HydraMed-Mobile and give my informed consent to the above.

**Patient/Parent/Guardian Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**