**PATIENT INFORMATION:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City/State/Zip Code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone Number(s)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_ **Height**: \_\_\_\_\_\_\_\_\_\_ **Weight**: \_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**:

* **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Telephone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications and Supplements**

(Including all prescription, over the counter, herbs, vitamins, and supplements, include all legal and illegal):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Route** | **Dose/Strength** | **Frequency** | **Last Time Taken** |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
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|  |  |  |  |  |

**Allergies** (drug, food, seasonal, LATEX): ⃞ NO KNOWN DRUG ALLERGIES

|  |  |
| --- | --- |
| **Name** | **Reaction** |
|  |  |
|  |  |
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|  |  |  |
| --- | --- | --- |
| **Please answer the following:** | **Yes** | **No** |
| 1. Are you pregnant or currently breastfeeding? |  |  |
| 1. Have you had surgery, been hospitalized or under the direct care of a physician in the past 6 weeks? |  |  |
| 1. Do you have, or have you had any of the following medical Problems? If YES, please explain next to diagnosis. |  |  |
| - Congestive Heart Failure (CHF) |  |  |
| - Chronic Obstructive Pulmonary Disease (COPD) / Diminished Respiratory Function |  |  |
| - Cystic Fibrosis |  |  |
| - Liver Disease |  |  |
| - Hepatitis |  |  |
| - Kidney Disease/Renal Insufficiency or Failure |  |  |
| - Leber's Disease |  |  |
| - Diagnosed Electrolyte Imbalances |  |  |
| - Organ Transplant |  |  |
| - DVT or Clots |  |  |
| - Heart Attack |  |  |
| - Stroke |  |  |
| - Coronary Artery Disease |  |  |
| - Elevated Blood Pressure or Hypertension |  |  |
| - Diabetes |  |  |
| - HIV/AIDS |  |  |
| - Seizures |  |  |
| - Muscular Dystrophy |  |  |
| - Cancer |  |  |
| - Immunocompromised |  |  |
| - Mental/Emotional Disorder |  |  |
| - Greater than 65 years of age |  |  |

|  |  |  |
| --- | --- | --- |
| **Please answer the following:** | **Yes** | **No** |
| 4. Do you currently take a blood thinner medications? If YES, please circle all that apply:  - Heparin (Fragmin, Lovenox, Innohep)  - Antithrombin (A Tryn, Thrombate III)  - Argatroban  - Dipyridamole (Persantine)  - Bivalirudin (Angiomax)  - Clopidogrel (Plavix)  - Warfarin (Coumadin, Jantoven) or specify: |  |  |
| 1. Do you currently take Lasix or any other diuretic (water pills)? Specify: |  |  |
| 1. Do you currently take or use any type of steroid? Specify: |  |  |
| 1. Do you have a current or ongoing infection? Specify: |  |  |
| 1. Do you depend on intravenous (IV) nutrition (TPN) or liquid nutrition products?  Specify:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 1. Any other medical conditions not specified, please list:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**PLEASE READ & INITIAL BELOW**:

\_\_\_\_\_\_ If you answered (“Yes”) to any of the above questions 1-8, it may be advised by the Medical Director of Bella Lei Aesthetics & Optimal Wellness that you **not** receive IV Therapy supplied by TruLife Pharmacy, and you may be denied services. You may only qualify to receive an IM if pregnant or breastfeeding.

\_\_\_\_\_\_ Bella Lei Aesthetics & Optimal Wellness reserves the right to refuse treatment at any time after a basic medical exam is completed.

\_\_\_\_\_\_ I understand that participating in the intramuscular (IM) and/or intravenous (IV) hydration and vitamin administration services provided by Bella Lei Aesthetics & Optimal Wellness, supplied by TruLife Pharmacy carries risks, which will be explained and provided to me in written and verbal form.

\_\_\_\_\_\_ I have truthfully answered all questions regarding my medical history to the best of my knowledge and have informed the staff about any and all prescription medications and/or over the counter drugs I take, as well as any street or recreational drugs. I understand that failing to inform the staff about my medical issues and/or drug use can lead to serious complications and I cannot hold Bella Lei Aesthetics & Optimal Wellness or TruLife Pharmacy liable in any manner.

\_\_\_\_\_ I acknowledge that I am responsible for any medical care I may have, that is directly or indirectly related to the services provided by Bella Lei Aesthetics & Optimal Wellness supplied by TruLife Pharmacy. If I seek medical treatment for any side effect or reaction, it will be at my own expense.

\_\_\_\_\_\_ I acknowledge and agree that the sole risk of injury or harm resulting in any manner from my voluntary participation in Bella Lei Aesthetics & Optimal Wellness IV/IM’s services, supplied by TruLife Pharmacy, rests entirely with me to the extent that I fail to disclose known or unknown health condition(s), medications, or drug use in advance of the services provided.

\_\_\_\_\_\_ I expressly represent and warrant to Bella Lei Aesthetics & Optimal Wellness, as well as TruLife Pharmacy, that I have never been diagnosed with or treated for any illnesses or conditions that may result in increased risk when participating in the services provided by Bella Lei Aesthestics & Optimal Wellness supplied by TruLife Pharmacy. I understand that Bella Lei Aesthetics & Optimal Wellness, as well as TruLife Pharmacy, bears no responsibility for and will not screen for, diagnose, monitor, or provide any care for such conditions.

\_\_\_\_\_\_ I acknowledge that Bella Lei Aesthetics & Optimal Wellness, as well as TruLife Pharmacy, relies upon information provided by me in assessing my ability to participate in the services provided.

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

Print Patient Name

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Patient Signature Date

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

Witness Signature Date

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

If Minor, Legal Guardian/Parental Signature Date

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

Medical Provider Signature Date