Injected Artistry, Inc. - IV Lounge Health History Form

Full Name: _____ **Date of Birth:** _____

Phone#: _____ **Address:** _____

Emergency Contact: _____ **Phone#** _____

Primary Care Physician: _____
Are you currently under the care of a physician, cardiologist (heart), pulmonologist (lungs), oncologist (cancer), or kidney doctor (dialysis)? **Yes / No**
If yes, please explain: _____

Any surgeries in the past year? **Yes / No**
If yes, please list: _____

Are you currently pregnant or breastfeeding? **Yes / No**

Do any of the following apply? **(Circle all that apply)** **If none, check here: [ ]**

Cardiac: High Blood Pressure, Heart attack, CHF, Arrhythmia, Coronary Artery disease, valve replacement, stents, bypass, pacemaker, High potassium or Low potassium	**Respiratory:** COPD, Asthma, Bronchiectasis, Bronchitis, pulmonary fibrosis, Pulmonary embolism, pneumonia, sarcoidosis, lung cancer **General Health:** Arthritis, Cancer Keloid Scarring, HIV/AIDS or HSV, Osteoporosis	**Neurological:** migraines/ headaches, anxiety, depression, history of traumatic brain injury, stroke, seizure disorder, brain cancer **Endocrine:** Diabetes, Thyroid, Hashimoto's, auto-immune disorder	**Gastrointestinal:** Regular diarrhea or constipation, leaky gut syndrome, Crohn's disease Diverticulitis, Reflux or GERD, Irritable bowel syndrome, Ulcerative colitis, Bariatric surgery	**Liver:** cirrhosis, gallstones, hepatitis **Kidneys:** kidney disease, Kidney stones, Kidney transplant **Bleeding disorder:** on blood thinners, clotting or excessive bleeding

If yes: _____

Are you taking any medications? **Yes / No**
If yes, please list: _____

Do you have any allergies? **Yes / No**
If yes, please list: _____

Are you taking any supplements? **Yes / No**
If yes, please list: _____

Are you taking any recreational drugs? **Yes / No**
If yes, please list: _____

I certify that the proceeding medical, surgical and personal health history statements are true and correct. I am aware that it is my responsibility to inform the nurse of ANY and ALL health conditions and current medication so they can treat me with the full understanding of contraindications. I also understand it is my responsibility to keep my health history form updated at future visits and inform the nurse treating me of ANY and ALL changes to my medical condition.

Print: _____ Sign:_____

Date: _____