Your Clinic Name

Good Faith Exam — IV Nutrition Therapy

IV hydration and vitamin infusions
Patient questionnaire to complete before your clinic's Good Faith Exam.

Part A — Patient completes

Do you have any of these right now?

- ☐ Chest pain or pressure
- ☐ Trouble breathing
- ☐ Fainting
- ☐ New confusion
- ☐ Sudden, severe headache
- ☐ Severe belly pain
- ☐ Vomiting blood or black stools
- ☐ Unable to keep fluids down for more than 24 hours
- ☐ None of these

If you checked any of these, tell a staff member right away. You may need urgent medical care instead of IV therapy.

Patient information

Full name _____ Preferred name (optional) _____

Date of birth _____ Phone _____ Email _____

Address

_____

_____

About your visit

Emergency contact: name, relationship, phone _____

What brings you in?

- ☐ Hydration
- ☐ Energy or wellness
- ☐ Recovery after exercise or travel
- ☐ Feeling unwell
- ☐ Other

Feeling unwell (describe) _____ Other _____

Which IV or ingredients are you interested in, if any? _____
Your provider will decide what is appropriate.

Health history

Check any you have now or have had before.

- ☐ None of these
- ☐ High or low blood pressure
- ☐ Heart disease, heart failure or irregular heartbeat
- ☐ Stroke, mini-stroke or blood clots
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Liver disease or hepatitis
- ☐ Autoimmune disease (for example lupus, rheumatoid arthritis, multiple sclerosis)
- ☐ Muscle or nerve condition (for example myasthenia gravis, Lambert-Eaton syndrome, ALS)
- ☐ Seizures or epilepsy
- ☐ Bleeding or clotting disorder
- ☐ HIV or another condition that weakens the immune system
- ☐ An infection or illness right now

☐ Cancer (current or past). If yes, type and any treatment in the past 12 months: _____

☐ Other condition: _____

Your Clinic Name
Patient name _____ Date of birth _____

Part A — Patient completes (continued)

Medicines and supplements

List all medicines, vitamins and supplements you take

_____

_____

_____

_____

	Yes	No
Do you take a blood thinner (for example warfarin, Eliquis, Xarelto, Plavix)?	☐	☐
In the past 7 days, have you taken aspirin, ibuprofen, naproxen, fish oil, vitamin E or ginkgo?	☐	☐

Allergies

☐ No known allergies ☐ Latex ☐ Tape or adhesive

Medicine allergies and what happened

_____

_____

Other (food, preservatives and so on): _____

Have you ever had a severe allergic reaction (trouble breathing, throat swelling) or been told to carry an EpiPen?	☐	☐

Pregnancy

Are you pregnant, trying to become pregnant, or breastfeeding?	☐	☐	☐ Does not apply

Questions about IV therapy

	Yes	No	
Do your legs or feet swell, or do you get short of breath when lying flat?	☐	☐	
Are you on dialysis, or have you had kidney stones?	☐	☐	
Have you been told you have G6PD deficiency (an inherited blood enzyme condition)?	☐	☐	☐ Not sure
Do you have iron overload (hemochromatosis)?	☐	☐	
Do you check your blood sugar with a meter or a sensor (CGM)?	☐	☐	
Have you been told your potassium, sodium or magnesium was too high or too low?	☐	☐	
Have you fainted or felt faint during a blood draw, shot or IV?	☐	☐	
Have staff had trouble finding your veins before?	☐	☐	
Have you had IV vitamin or hydration therapy before?	☐	☐	

Any reaction? What was in it, if you know? _____

Have you had alcohol or recreational drugs in the past 24 hours?	☐	☐

Symptoms today:
☐ Fever ☐ Vomiting ☐ Diarrhea ☐ Headache ☐ Dizziness ☐ None ☐ Other: _____

Patient statement and signature

I have answered these questions completely and truthfully to the best of my knowledge. I understand the prescriber will use my answers to decide whether this treatment is right for me, and that this exam does not guarantee I will be treated. I will tell the clinic before treatment if my health, medicines, allergies or pregnancy status change.

Patient signature _____ Printed name _____ Date _____

If signed by a legal representative: name and relationship _____