MAXLIFE IV

Patient Name _____Date of visit _____

Date of Birth _____ Phone number_____Gender _____

Mailing address _____

Driver's License _____ Last 4 of SSN _____ Email _____

Medical Questionnaire

(Please circle Yes or No)

Medical History

Diabetes	Yes	No	Liver Disease	Yes	No
Heart Attack	Yes	No	Migraines	Yes	No
Congestive Heart Failure	Yes	No	Kidney Disease High	Yes	No
High Blood Pressure	Yes	No	Cholesterol Stroke / TIA	Yes	No
Heart Disease	Yes	No	Major Depression	Yes	No
Bleeding Disorder	Yes	No	Hepatitis	Yes	No
HIV / AIDS	Yes	No	Leg Swelling Issues	Yes	No
Tuberculosis	Yes	No	Bowel Problems	Yes	No
Fibromyalgia	Yes	No	Epilepsy / seizures	Yes	No
Malnutrition	Yes	No		Yes	No

Other medical issues _____

Surgical History

Heart	Yes	No	Bladder	Yes	No
Bowel	Yes	No	Back / Spine	Yes	No
Mastectomy	Yes	No	Arms / Legs / Hip(s)	Yes	No

Other surgical issues _____

Current Medications? (pills, injections, patches, over the counter, vitamins, etc) ☐ List provided

_____

_____

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_____

Any problems with IVs or IV treatments in the past?

_____

Allergies to medications or other substances?

Sulfa allergy Milk allergy Lactose Intolerance (NO Glutathione if one of these is YES)

Specific medications or substances you are allergic to _____

Potential Substance Use? (Please list how much, how often, last use)

Alcohol consumption Yes No _____
Nicotine smoking Yes No _____
Marijuana smoking Yes No _____
Other substances Yes No Opiates Cocaine Methamphetamine _____

Social History Single Married Divorced Separated Widowed Widower Cohabiting

Usual Physical Activity Level Inactive Light Activity Moderate activity Heavy Activity

Main reason for seeking treatment with us today? (short explanation)

Lethargy / Tiredness / Overdid it _____

Discomfort / Pain _____

Detoxification in General _____

Headache / Stressed Out _____

Residual / Current Illness _____

Hangover / Jet lag _____

Gastrointestinal distress _____

Poor Sleep / Poor Nutrition _____

Boost Your Immunity _____

Other Issue _____

Provider Signature _____

Hormonal Imbalance or Dysfunction Questionnaires

Female identifying:

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Male Identifying:

__ Decreased libido or sex drive?
__ General lack of energy for daily activities?
__ Decreased in strength / endurance?
__ Relatively recent weight gain / fat gain?
__ Noticed problems with your sleeping?
__ Are you sad or depressed?
__ Had an overall decline in general health?
__ Falling asleep too easily after dinner?
__ Doing less at work from easy fatigue?
__ Hands / feet intolerance to hot or cold?
__ Brittle or coarse hair or hair loss?
__ Do you experience ‘brain fog’?
__ Do you have overly dry skin?
__ Does your skin itch in the winter?
__ Do you have decreased body hair?
__ Slow pulse, low blood pressure, apnea?
__ Decreased sweating or low body temp?