Patient Name

New Patient Health Questionnaire for Wellness Vitamin Injections

First Name:_____ Last Name:_____ Date:_____

DOB:_____ Home Phone:_____ Mobile Phone: _____

Email address:_____ Receive email announcements/newsletters/updates/offers? ❑Y ❑N

*(*Axiva will never sell, lease, or otherwise disclose your email address/personal information.)*

Address:_____

Emergency Contact Name:_____ Relationship:_____ Phone Number:_____

What medical concerns bring you to our office? _____

Have you ever smoked? ❑ No ❑Yes ❑Cigar ❑Pipe ❑Cigarettes If *Yes*: #cigarettes/day____#yrs._____

If you have never smoked, skip this question: Do you still smoke now? ❑No ❑Yes If *No*, when did you quit? _____

Alcohol: Do you drink alcohol regularly? ❑No ❑Yes #/day _____

Recreational Drugs: Do you use recreational drugs? ❑No ❑Yes #/day _____

Medical Information

Allergies: Are you allergic to any drugs? ❑ No ❑Yes Please list:_____

Allergies: Are you allergic to any foods? ❑No ❑Yes Pleaselist:_____

Medications *(list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Illnesses or Conditions *(list any chronic conditions which you have been diagnosed to have)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had or been diagnosed to have: *(check box by all that apply)*

POTS/ Dysautonomia		Heart Disease		Eczema/Psoriasis		Anemia		Depression/Anxiety	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Frequent Infections	
Asthma		High Blood Pressure		Lyme Disease/ Co-Infections		Bone/Joint Disease		Cancer (type)	
Allergies		Pneumonia		Kidney Disease					
Stroke		TB/COVID-19		Kidney Stone(s)		Chronic Fatigue Syndrome		ADD/ADHD	
Seizures/Epilepsy		SIBO		Diabetes or Pre-Diabetes		Migraines		Neuropathy	
Heart Attack or Angina		Jaundice or Liver Disease		Eating Disorder		Chronic EBV/ HHV-6		Mold/Biotoxin Illness	

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Operations:
Please list any surgery and approximate year

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations:
Other than operations

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are your medical complaints? *(check box by all that apply)*

Fatigue or low energy		Asthma and Allergies	
Stress		Recent surgical procedure	
Poor diet due to busy lifestyle		Recent illness	
Low mood or depression		Cold or flu symptoms	
Headaches or migraines		Facial wrinkles or fine lines	
Weight gain or difficulty losing weight		Dull or dry skin	
Slow metabolism		Malabsorption issues	
Decreased or low appetite		Hangover	

Height: _____ **Weight:** _____

Females Only: Are you pregnant, planning a pregnancy or nursing a child? ❑No ❑Yes

Have you previously received a vitamin injection? ❑No ❑Yes If yes, when: _____

Have you ever been treated for or suspected of having excess/overdose of vitamins, minerals or electrolytes? ❑No ❑Yes

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How did you hear about us?

❑Internet ❑ Social Media ❑ Walk-in ❑ Radio ❑ Friend _____

I certify that the information provided by me on this form is, to the best of my knowledge, accurate and complete. I acknowledge that withholding any medical information may increase the risk of harm from any treatment I receive.

Patient Signature: _____ Reviewed by: _____

Date: _____ Date: _____

Please print the completed form and bring with you to your appointment or fax the completed form to 800.334.2252. Do not email your form. Be advised that use of email is inherently insecure. Confidential information, including confidential information and personally identifiable information, transmitted via email or email attachment could be lost, used, or misused.

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