

**MEDICAL HISTORY QUESTIONNAIRE & INFORMED CONSENT FORM FOR  
INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IVMNS)  
FOR *NON-MEDICINAL* INDICATIONS**

This is your medical history form, to be completed prior to your first INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION session with The IV Clinic.

All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin the supplementation program.

If you have questions or concerns, we will help you with those after this form is completed.

<b>Full Name:</b>		<b>Date of Birth:</b>	
<b>Address:</b>			
<b>Telephone:</b>		<b>Mobile:</b>	
<b>Email:</b>			
<b>Marital Status:</b>	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed		
<b>Sex:</b>	<input type="radio"/> Male <input type="radio"/> Female		
<b>GP Name:</b>		<b>GP Practice Name:</b>	
<b>Consultant: &amp; Care Centre (if applies)</b>			

I give / do not give my permission to discuss with or inform my GP or Consultant about the intravenous micronutrient supplementation that I am about to / wish to receive.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

## PRESENT MEDICAL HISTORY

Smoking:	/week	Alcohol Intake:	/units week
What is your purpose of having IV therapy?			
Have you any history of receiving IV's before?			
Are you scared of needles/needle phobic?			
Do you faint easily when you have blood taken?			
List any prescription medications you are now taking:			
List any drug or other causes of allergies:			
List any self prescribed medications, dietary supplements, or vitamins you are now taking:			
List any other medical or diagnostic test you have had in the past two years:			
List hospitalisations, including dates of and reasons for hospitalisation:			
MEN ONLY: Do you have any prostate problems, erectile dysfunction or taking testosterone?			

<b>WOMEN ONLY: Are you pregnant/ breastfeeding or suffering with menstrual problems?</b>			
<b>Emergency Contact Name:</b>		<b>Contact Telephone</b> :	

**Check those questions to which you answer yes (leave the others blank).**

- Has a doctor ever said your blood pressure was too high?
- Do you ever have pain in your chest or heart?
- Are you often bothered by a thumping of the heart?
- Does your heart often race?
- Do you ever notice extra heartbeats or skipped beats?
- Are your ankles often badly swollen?
- Do cold hands or feet trouble you even in hot weather?
- Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- Do you suffer from frequent cramps in your legs?
- Do you often have difficulty breathing?
- Do you get out of breath long before anyone else?
- Do you sometimes get out of breath when sitting still or sleeping?
- Has a doctor ever told you your cholesterol level was high?

**Do you now have or have you recently experienced:**

- Chronic, recurrent or morning cough?
- Episode of coughing up blood?
- Increased anxiety or depression?
- Problems with recurrent fatigue, trouble sleeping or increased irritability?
- Migraine or recurrent headaches?
- Swollen or painful knees or ankles?
- Swollen, stiff or painful joints?
- Pain in your legs after walking short distances?
- Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- Significant vision or hearing problems?
- Glaucoma or increased pressure in the eyes?
- An infection such as pneumonia accompanied by a fever?
- Significant unexplained weight loss?
- A deep vein thrombosis (blood clot)?
- Foot or ankle sores that won't heal?
- Skin allergies?
- Persistent pain or problems walking after you have fallen?
- Eye conditions such as bleeding in the retina or detached retina?

- Cataract or lens transplant?
- Leukemia or cancer?
- Receiving chemotherapy?
- In remission following cancer chemotherapy?

**Women only answer the following:**

- Any menstrual period problems?
  - Are you pregnant?
  - Significant childbirth - related problems?
  - Are you breastfeeding?
  - Urine loss when you cough, sneeze or laugh?
  - Are you on any type of hormone replacement therapy?
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**Men only answer the following:**

- Do you have Prostate problems?
- Do you have Erectyle dysfunction?
- Are you taking hormone replacement i.e. testosterone?
- When was your last PSA bloodtests?

**PAST MEDICAL HISTORY**

**Check those questions to which your answer is yes (leave others blank).**

- Heart attack if so, how many years ago? \_\_\_\_\_
- Rheumatic Fever
- Heart murmur
- Diseases of the arteries
- Anaemia
- G6PD deficiency
- Varicose veins
- Arthritis/Gout of legs or arms
- Diabetes or abnormal blood-sugar tests
- Phlebitis (inflammation of a vein)
- Deep vein thrombosis/blood clot in the leg
- Dizziness or fainting spells
- Epilepsy or seizures
- Stroke
- Scarlet Fever
- Infective endocarditis
- Infectious mononucleosis
- Nervous or emotional problems
- Thyroid or Parathyroid problems
- Adrenal gland problems
- Pancreas/digestion problems
- Stomach/duodenum ulcer
- Pneumonia

- Bronchitis
- Emphyzema
- Asthma or Hay fever
- Abnormal chest X-ray
- Other lung disease
- Kidney disease
- Broken bones/osteoporosis
- Jaundice or gall bladder problems
- Leukemia or cancer

### **INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION CONSENT**

Before you choose to use the services of The IV Clinic please read the following information fully and carefully:

#### **WHY INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION?**

The main benefits may include:

1. Injectable micronutrients are not affected by stomach, or intestinal absorption problems
2. Total amount of infusion/injection is available to the tissues
3. Nutrients are forced into cells by means of a high concentration gradient
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation

***I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.***

**GOALS:** The basic goal is to encourage people to become (1) knowledgeable about and responsible for their own health, (2) and to bring it to a personal optimum level, (3) to delay the aging process and to (4) enhance your metabolism.

INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IVMNS) is designed to improve your optimum health, absent of other non-nutritional complicating factors, and requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. It is not intended to make a medical diagnosis and to recommend any medicinal treatment(s).

No comment or recommendation should be construed as inferring or implying a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IVMNS). Medication and or medical conditions may have a negative impact on the positive effects of IVMNS.

**HEALTH CONCERNS:** If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider such as your GP or Consultant. If you are under the care of another healthcare provider, it is important that you to inform your other healthcare providers of your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert The IV Clinic and their

practitioner to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist. If you have any physical or emotional reaction to INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IVMNS), discontinue use immediately, and contact your practitioner to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the supplementation.

### Photography/filming consent form (Data Protection Act 1998)

We would like to take photos/film and/or comments of you as part of your clinical records of the day and for promotional purposes.

These images may appear on our website and email newsletters, in our printed materials produced for promotional purposes including leaflets, posters and adverts, in materials sent out to the media, or in reports to funding bodies.

We will not include personal e-mail or postal addresses, or telephone or fax numbers on our website or in printed publications. Please note that websites can be seen throughout the world, and not just in the United Kingdom, where UK law applies.

To comply with the **Data Protection Act 1998**, we need your permission before we take any photographs/film of you.

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Please answer the questions below, then sign and date the form as indicated. **Conditions of use:**

1. This form is valid for five years. We will not use the photographs/film for any other purposes than those mentioned above.
2. We will not include personal details (such as postal addresses, or telephone number) on our website, printed. Materials or other marketing/promotional materials. Copyright of photographs taken will remain with the organization named above  
***Please note that websites can be seen throughout the world, and not just in the United Kingdom, where UK law applies.***  
Do you give us permission? *(Please tick as appropriate)*

YES

YES for medical records only not for other use

NO

Laboratory testing may be done to determine areas of dysfunction, not to diagnose or treat. Lab testing can assist in revealing nutrient deficiencies and weaknesses.

**COMMUNICATION:** Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct possible imbalances.

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the selected IVMNS protocol
2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes
3. Several supplementation sessions may be required
4. Risks of intravenous therapy includes but is not limited to:
  - a. Occasionally to commonly: discomfort, pain and bruising ant injection site
  - b. Rarely: inflammation in the vein used, phlebitis, metabolic disturbances
  - c. Extremely rarely: severe allergic reaction, anaphylaxis, systemic infection, cardiac arrest and death

I am aware that other unforeseeable complications could occur. I do not expect The IV Clinic and their practitioners to anticipate and or explain all risks and possible complications. I rely on them to exercise judgment during the course of therapy with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

I understand that I have the right to consent to or refuse any proposed therapy at any time prior to its performance. *At any stage during the infusion/injection, I have the right to request that the procedure is terminated, however I accept that I will not be reimbursed once the IV or IM procedure or supplementation has commenced.*

My signature on this form affirms that I have given my full consent to receive an INTRAVENOUS MICRONUTRIENT SUPPLEMENTATION (IVMNS) protocol from The IV Clinic.

**PATIENT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRACTITIONER NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CLINIC LOCATION:** \_\_\_\_\_ **PRACTITIONER NO:** \_\_\_\_\_