GOAL Family Medical P.C.
Compassion. Dedication. Trust.

IV Therapy Questionnaire

Full Name _____ DOB __/__/__ Contact Phone _____

IV Therapy can provide the following: Boost energy, treat chronic pain, restore hydration, enhance immune function, promote sports recovery, relieve menstrual discomfort, relieve mild headaches, increase relaxation

1. Are you interested in receiving IV therapy in our office?

◯ Yes ◯ No

If yes, proceed to the following questions:

2. Do you have any medical conditions? Please select all that apply.

◯ Diabetes ◯ Heart disease ◯ Liver disease ◯ Kidney disease

◯ Hypertension ◯ Bleeding disorders ◯ Autoimmune disorders

◯ Cancer

Other medical conditions (please specify): _____

3. Are you currently taking any medications?

◯ Yes, List _____

◯ No

4. Are you pregnant or breastfeeding?

◯ Yes ◯ No

5. Do you smoke cigarettes?

◯ Yes ◯ No

6. Have you ever received IV therapy before?

◯ Yes ◯ No

7. Have you had any recent surgeries, hospitalizations, or blood transfusions?

◯ Yes ◯ No

8. Do you have any known food, environmental, or medication allergies?

◯ Yes, List_____ ◯ No

Thank you for completing the questionnaire. Please return this form to the front desk or hand it to your healthcare provider during your appointment.

Dr. Ogadinma McGeachy
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