



RAPID IV PATIENT INTAKE FORM

PATIENT INFORMATION

Today's Date: ____/____/____ Name: _____
Last Name First Name Middle Initial

DOB: ____/____/____ Age: ____ Gender: M F Height: ____ Weight: ____

Address: _____
Street City State Zip Code

Home: (____) _____ Cell: (____) _____

Email: _____

Emergency Contact: _____ Emergency Phone: (____) _____

Address: _____
Street City State Zip Code

Relationship to Patient: _____

CURRENT MEDICATIONS AND SUPPLEMENTS	DOSE

ALLERGIES	REACTION

MEDICAL AND SURGICAL HISTORY

SURGERIES	DATE

PAST MEDICAL HISTORY

- Anemia
- Asthma
- Bone Disorders
- Cancer
- COPD
- Difficult Veins
- Diabetes
- Heart Attack
- Heart Disease
- Hypothyroidism
- Kidney Disease
- Liver Disease
- Lupus
- Seizures
- Syncope/Near Syncope
