

National Infusion Services

PATIENT INFORMATION:

Date: _____

Name: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____

Work: _____

Social Security #: _____ Date of Birth: _____

Primary Care Giver/Significant Other:

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Emergency Contact::

Name: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Delivery Address (if different from above):

Address: _____

City: _____ State: _____ Zip: _____

Insurance:

Primary: _____ Policy #: _____

Secondary: _____ Policy # _____

Referring Physician: _____

National Infusion Services

Name: _____ DOB: _____ Date: _____

PATIENT HISTORY

MOBILITY: Do You Use...

- Crutches/Cane Walker Wheelchair Total Assist No Assist Needed
 History of Falls Explain: _____

SOCIAL HISTORY: Do You...

- Use Illicit Drugs Use Alcohol Use Tobacco
 Have Cultural/Religious issues affecting your care None

HOME SAFETY: Do You Have...

- Electricity Telephone Running Water Refrigeration Smoke Detector
 Fire Evacuation Route Appropriate Area to Prepare Medication and Store Supplies
 Pets

NUTRITION HISTORY:

- Regular Diet Low Salt Diabetic Diet _____kcal Enteral
 other diet: _____ Have you Lost or Gained 10# or more in last 3 months

COMMUNICATION:

- No Concerns Hearing Impaired Vision Impaired

Are you pregnant or breast feeding? Yes No

Do you currently have an IV line/site in place? Yes No Where? _____

Have you had any surgical procedures? Please List (past 5 years):

Pain: Yes No Location: _____

If yes, please circle intensity: 1 2 3 4 5 6 7 8 9 10

Quality: sharp burning aching dull throbbing other _____

Frequency: constant occasional infrequent when I move _____

Relief Measures: _____ Effective: Yes No

PATIENT/FAMILY MEDICAL HISTORY:

Have you or any blood relatives ever had or still have (Check for yes):

Pt	Fmly		Pt	Fmly		Pt	Fmly	
		Heart Disease			Diabetes			Cancer: _____
		Bleeding Problems			Kidney/Bladder Disease			Epilepsy/Convulsions
		High Blood Pressure			Liver Problems/Jaundice			Thyroid Problems
		Circulation Problems			Lung or Breathing Problems			Skin Problems
		Stroke			Sinus/Allergy Problems			Mental Illness: _____
		Anemia/Sickle Cell			Tuberculosis			Nervous Problems: _____
		Migraines			Stomach, Intestine, Bowel Problems			Sexually Transmitted Disease
		Paralysis			Arthritis			HIV or AIDS related Illness
		Open Wound: _____			Gout			

