

MAC Wellness Center-Ketamine Infusion Therapy

Patient Health History

Last Name:		First Name:		DOB:	Age:
					o □ Yes,
Preferred Care Pro	vider:		Mental He	alth Provider:	
				-	
Past Medical I	listory:				
Yes No			Yes		
	inal aortic an	eurvsm		☐ Sickle Cell disea	se
☐ ☐ Adrenal disease				☐ Sleep apnea	
	ner's disease,	dementia		\square Yes, Use CPA	P at night
□ □ Anemia	-			☐ Snoring	
☐ ☐ Arthrit	S			☐ Spine/Neck disc	orders
□ □ Asthma	1			☐ Stomach ulcers	
□ □ Bleedir	g Disorder			☐ Stroke	
☐ ☐ Blood o	-			☐ Thyroid disease	
☐ ☐ Cancer				☐ Vascular disease	
☐ ☐ Carotid	artery diseas	se		☐ Other	
☐ ☐ Crohn's	•				
\Box \Box COPD				Psychiatric History	y :
□ □ Conges	tive heart fai	ure (CHF)	Yes	_	
□ □ Corona	ry artery dise	ase		☐ Anxiety	
□ □ Diabete	es Type I or Ty	/pe II		☐ Bipolar Disorde	ſ
□ □ Emphy	sema			☐ Depression	
☐ ☐ Fibrom	yalgia			□ OCD	
☐ ☐ Epileps	y/Seizures			□ PTSD	
□ □ Heart a	ttack/MI			☐ Suicidal Ideation	
□ □ Heart r	nurmur			☐ Previous Ketam	• •
□ □ Heartb	ırn, reflux, oı	GERD		⊔ Otner	
□ □ Hepati	is		Casi	al III aka	
□ □ Liver d	sease			al History:	
□ □ High bl	ood pressure			No	
☐ ☐ High ch	olesterol			☐ Smoke tobacco	
☐ ☐ HIV/AII	OS			☐ Use Alcohol	_
□ □ Irregul	r heartbeat			☐ Use Illegal drugs	
□ □ Kidney	disease			Other	
☐ ☐ Lung di	sease		Denia	r/Food Allowaica. [Nono □ Vos
□ □ Supple	mental oxyge	n		g/Food Allergies:	
_	ant hyperthe	rmia	ii yes	s, list name and rea	action below:
	olic disorder				
☐ ☐ Osteop					
	aker/Defibrill				
	ary embolus				
	atoid disease				
☐ ☐ Serious	infection				



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	Year		
Anesthesia History: None			
Please explain any yes answers b	elow		
Yes No	· - el- agia ar	derten bestana)	
☐ Have you had general an☐ Did you have any complice			
☐ ☐ Were you told it was difficult.			
•		problems with anesthesia <u>oth</u>	n <u>er than</u> nausea or slow
awakening?			
Explanation:			
Previous Hospitalizations:		Year	
	d/OTC/Supp	olements): ☐ None	
Current Medications (Prescribed	= =	-	
Current Medications (Prescribed Medication	Dose	Directions for Use	Reason
	Dose	-	Reason
Medication		Directions for Use	
Medication	ormation abou	Directions for Use	e my safety. Therefore, I
Medication	ormation abou	t my health history could jeopardize	e my safety. Therefore, I truthfully and to the best
I understand that withholding any info have completed/reviewed this health I of my knowledge. I hereby give permis information with the below provider(s	ormation abou history careful ssion to Mobile a) and/or hospi	t my health history could jeopardize ally and have answered all questions e Anesthesia Care to discuss/share/vital as needed. <i>Check all that apply</i>	e my safety. Therefore, I truthfully and to the best obtain pertinent medical below:
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