

## New Adult Patient Questionnaire

Date:

# **ALL INFORMATION IS STRICTLY CONFIDENTIAL**

#### **PERSONAL INFORMATION**

Name:	Surname:
Date of Birth: / /	Age: years old
Male/Female:	Marriage status:
Occupation:	Nationality:
Physical Address:	Email:
	Mobile number:
	Home number:
	Work number:
Postal Address: (if different from above)	

General Practitioner's (GP) Name & Practice Address:
GP Contact number:
GP Contact number:

#### **YOUR PERSONAL MEDICAL HISTORY:**

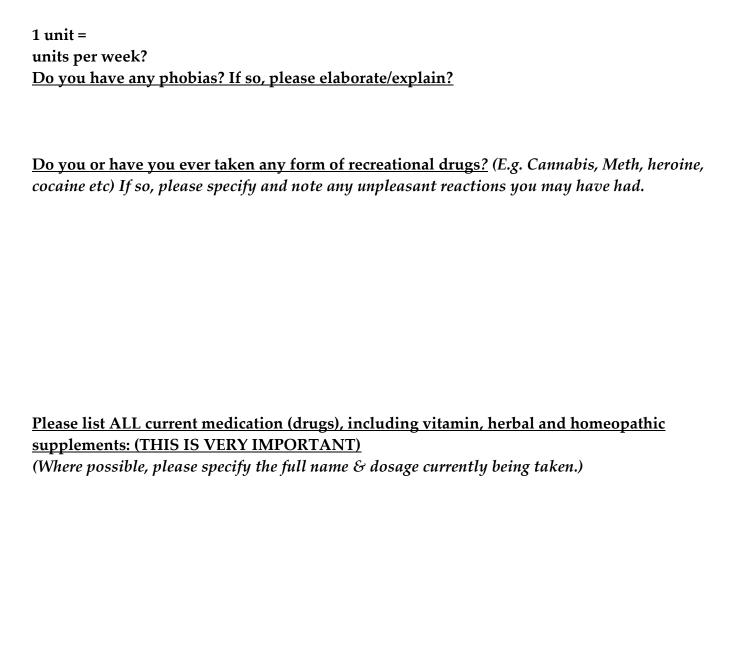
(PLEASE BE REMINDED ALL INFORMATION IS STRICTLY CONFIDENTIAL AND FULL DISCLOSURE WILL ONLY BE TO YOUR BENEFIT IN YOUR HEALTH MANAGEMENT)

### Please tick (✓) any applicable health conditions below:

Condition	Condition	Condition
Diabetes mellitus (type 1, type 2/ gestational)	Depression	Glandular fever (Epstein Barr Virus)
High Cholesterol	Anxiety	ТВ
High Blood pressure	Strep throat	Rosacea
Low Blood Pressure	Scarlet fever	Tick Bite Fever (Lyme Disease)
Overactive thyroid	Malaria	Hypermobility
Underactive thyroid	Hepatitis	Sexually Transmitted Disease (Chlamydia, HPV, Gonorrhea, Syphilis, HIV)
Eczema	Measles	
Asthma	Mumps	
Cancer/tumors	Chickenpox / Shingles	

<u>Please list any other medical conditions not listed above:</u>

Have you had all the standard childhood immunisations? Please specify any reactions you may have had if at all possible.
Please indicate any past surgical procedures, their respective dates & any complications experienced:
GENERAL QUESTIONS
Do you feel warmer / colder than most around you? Yes / No (please circle)
Do you perspire? Yes / Rarely (please circle)
Where do you tend to perspire? (E.g. under arms, along brow, upper lip, inner thigh, down back etc)
Do you have any weather preferences (weather you particularly like)? (E.g. Rainy, cold, dry hot, humid hot, warm but not sunny)
Does wind aggravate or bother you? Yes / No (please circle)
Do you smoke? Yes / No (please circle) If yes:
What brand: How many on average do you think you have per day? (1-10) (10-20) (20-30) (30-40) (please circle)
How long have you been smoking for?  Do you drink alcohol? Yes / No (please circle)



### **Family Medical History:**

Please let me know if any of the following family members have suffered from any of the following:

Cancer, Heart disease, TB, Diabetes, Thyroid conditions, Sexually Transmitted Infections, Alzheimers Disease, Dementia, Multiple Sclerosis, Mental illness / handicap, Schizophrenia, Eczema, Psoriasis, Migraine, Epilepsy, Allergies, Asthma, Drug / Alcohol addiction, Arthritis, Anaemia or any other illness you may think significant.

(If deceased, please kindly indicate the age and cause of death if known.) **Your Mother Your Father Maternal Grandmother** Maternal Grandfather Paternal Grandmother Paternal Grandfather

Your Children (if Applicable):

**Your Siblings** 

s there any other information you may want to add or you feel is important for me to know?	
<u> Cerms &amp; Conditions for Novus Vita Health Ltd (trading as "Novus Vita")</u>	
<ul> <li>I have answered all the above questions to the best of my knowledge and will undertake to inform Novus Vita of any alterations to the above as soon as possible in writing.</li> <li>I understand and I am fully aware that the advice and treatments recommended by Novus Vita are taken a own discretion. I also understand that Novus Vita does not intend to diagnose any medical conditions and will assume no medical or legal liability of such kind.</li> <li>I understand that email correspondence is not a secure form of communication. Someone else could change the content or read the emails before they arrive. I will limit the extent to which personal or sensitive information is sent by me to Novus Vita by email</li> <li>I accept that any legal disputes arising in relation to the services provided by Novus Vita will be governed English laws and is subject to the exclusive jurisdiction of the English courts.</li> <li>I am aware of and give consent to Novus Vita to use my case for education or research purposes, and I understand that my personal information will never be disclosed unless I have authorised so in writing.</li> <li>I understand my responsibility to settle all payments promptly and agree to the fee structure as laid out by Novus Vita.</li> <li>I accept that Novus Vita operates a 24hr cancellation policy. Patients and prospective patients are required give 48 hours notification of cancellation in writing to drcahill@novusvita.co.uk failing which the full consultation fee shall be payable.</li> </ul>	nt my d ge I by
Date:	
Patient's Full Name (print): Patient's Signature:	



Novus Vita Health Ltd.