Novus Vita Health Ltd. Company Reg. No. ***11294130***

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: _____

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:

- **Diabetes mellitus (type 1, type 2 / gestational)** □
- **Hypercholesterolaemia (High Cholesterol)**
- **Hypertension (High blood pressure)**
- **Hypotension (Low blood pressure)** □
- **Hyperthyroidism (overactive thyroid)**□
- **Hypothyroidism (underactive thyroid)**
- **Asthma**
- **Arthritis**
- **Cancer/Tumors**
- **Depression / Anxiety**
- **Scarlet fever / Rheumatic fever**
- **Strep (bacterial infection) throat**□
- **Tuberculosis** □
- **Typhoid** □
- **Sexually transmitted diseases (chlamydia, HPV, Herpes, gonorrhea, syphilis, HIV)** □
- **Malaria** □
- **Hepatitis** □
- **Measles** □ □
- **Mumps** □ □
- **Glandular Fever (Epstein-Barr virus)**□
- **Chickenpox / Shingles**
- **Tick Bite Fever (Lyme Disease)**

Please list any other medical conditions not listed above:

Have you had all the standard childhood vaccinations? P*lease specify any reactions you may have had if at all possible.*

Please indicate any past surgical procedures, their respective dates & any complications:

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)*

Do you drink alcohol? Yes / No *(please circle)*
1 unit =
units per week?

Do you have any phobias? If so, please elaborate/explain?

Do you or have you ever taken any form of recreational drugs? ***(E.g. Cannabis, Meth, heroine, cocaine etc) If so, please specify…***

Please list all current medication (drugs), including vitamin, herbal and homeopathic supplements: (THIS IS VERY IMPORTANT)
(Where possible, please specify the full name & dosage currently being taken.)

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

Is there any other information you may want to add or you feel is important for me to know?

Terms & Conditions for Novus Vita Health Ltd (trading as "Novus Vita")

- **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.**
- **I understand and I am fully aware that the advice and treatments recommended by Novus Vita are taken at my 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.**
- **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**
- **I accept that any legal disputes arising in relation to the services provided by Novus Vita will be governed by English laws and is subject to the exclusive jurisdiction of the English courts.**
- **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.**
- **I understand my responsibility to settle all payments promptly and agree to the fee structure as laid out by Novus Vita.**
- **I accept that Novus Vita operates a 24hr cancellation policy. Patients and prospective patients are required to give 24 hours notification of cancellation in writing to drcahill@novusvita.co.uk failing which the full consultation fee shall be payable.**

Date:_____ **Patient's Signature:**_____

Place:_____

Novus Vita Health Ltd.

Dr. Jodi Cahill M.Tech.Hom(SA), PGCE (DTTLS)

Homeopathic Doctor, Naturopathic Practitioner and Registered Homotoxicologist