CONFIDENTIAL- FOR MEDICAL PURPOSES ONLY

SAVE
and send after filled in form as an attachment to:
inquiry@biomedic.co.uk

BIOMEDIC ASSESSMENT FORM

Forenames: _____ **Surname:** _____ **Ref. no.:** _____

Date of birth: _____ **Today's date:** _____

Address: _____

_____ **Postcode:** _____

Telephone: _____ **Work:** _____ **Mobile:** _____

Occupation: _____ **E-mail:** _____

I am: ◯ *Single* ◯ *Married* ◯ *Divorced* ◯ *Separated* ◯ *Widowed* ◯ *With partner*

I live with: ◯ *Spouse* ◯ *Partner* ◯ *Friend* ◯ *Children* ◯ *Parents* ◯ *On my own*

I am currently: ◯ *Employed* ◯ *Unemployed* ◯ *Self Employed* ◯ *Retired*

My current **Health concern** is/are:

_____

_____

PREGNANCY/BIRTH

Did **your mother's pregnancy** progress to full term in a healthy manner, and if not, please explain:

☐ Yes ☐ No

_____

Was it followed by a normal vaginal delivery, and if not, please explain: ☐ Yes ☐ No

_____

Have you been breastfed, and if yes, for how long? ☐ Yes, for _____ months ☐ No

MEDICAL HISTORY

Please list all **diseases, physical traumas and operations** that you have had and your **age** when they occurred:

	Age		**Age**
1. _____	_____	7. _____	_____
2. _____	_____	8. _____	_____
3. _____	_____	9. _____	_____
4. _____	_____	10. _____	_____
5. _____	_____	11. _____	_____
6. _____	_____	12. _____	_____

Please tick for the past or current **tendencies to frequently experience** the following:

Skin irritation	☐ No	☐ Yes, in the past	☐ Yes, currently
Muscles and joint pain/aches	☐ No	☐ Yes, in the past	☐ Yes, currently
Excessive sweating	☐ No	☐ Yes, in the past	☐ Yes, currently
Indigestion	☐ No	☐ Yes, in the past	☐ Yes, currently
Bloating/flatulence	☐ No	☐ Yes, in the past	☐ Yes, currently
Constipation	☐ No	☐ Yes, in the past	☐ Yes, currently
Diarrhoea	☐ No	☐ Yes, in the past	☐ Yes, currently
Appetite oscillations	☐ No	☐ Yes, in the past	☐ Yes, currently
Breathing difficulties	☐ No	☐ Yes, in the past	☐ Yes, currently
Palpitation	☐ No	☐ Yes, in the past	☐ Yes, currently
Frequent urination	☐ No	☐ Yes, in the past	☐ Yes, currently
Tiredness	☐ No	☐ Yes, in the past	☐ Yes, currently
Emotional difficulties	☐ No	☐ Yes, in the past	☐ Yes, currently
Insomnia	☐ No	☐ Yes, in the past	☐ Yes, currently
Frequent infections	☐ No	☐ Yes, in the past	☐ Yes, currently

Others _____

_____

Females only

Age at onset **menstruation?** _____

Age at onset **menopause?** _____

Have you taken **oral contraceptive pills?** ☐ No ☐ Yes, how long? ____ months

Have you taken **Hormone Replacement Therapy (HRT)?** ☐ No ☐ Yes, how long? ____ months

Have you ever **experienced** any of the following? (Please tick)

☐ Irregular periods	☐ Uterine fibroids	☐ Extra uterine pregnancy
☐ Absence of period	☐ Normal birth	☐ Eclampsia
☐ Metrorrhagia (haemorrhage)	☐ Miscarriage	☐ Diabetes during pregnancy
☐ Infection in reproductive organs	☐ Abortion	☐ Placenta praevia
☐ Ovarian cyst	☐ Still birth	☐ Infertility
☐ Endometriosis	☐ Premature birth	☐ Cervical dysplasia

Family History

Please fill in the relevant medical details of **your family members.**

Diseases:			**Family member:**
Malignant Diseases:	☐ Yes	☐ No	_____
Congenital disease:	☐ Yes	☐ No	_____
High Blood Pressure:	☐ Yes	☐ No	_____
Heart disease:	☐ Yes	☐ No	_____
Blood disease:	☐ Yes	☐ No	_____
Lung disease:	☐ Yes	☐ No	_____
Stomach disease:	☐ Yes	☐ No	_____
Bowel disease:	☐ Yes	☐ No	_____
Liver/gall bladder disease:	☐ Yes	☐ No	_____
Kidney disease:	☐ Yes	☐ No	_____
Arthritis:	☐ Yes	☐ No	_____
Bone disease:	☐ Yes	☐ No	_____
Diabetes:	☐ Yes	☐ No	_____
Thyroid problem:	☐ Yes	☐ No	_____
Stroke:	☐ Yes	☐ No	_____
Multiple sclerosis:	☐ Yes	☐ No	_____
Epilepsy:	☐ Yes	☐ No	_____
Psychiatric disease (depression):	☐ Yes	☐ No	_____

Other, please specify: _____

_____

Please give **name, dosage and frequency** of any current **medication** and when you started taking it:

Current medication:	**Start date:**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

If you are currently receiving/practicing any **alternative therapy(s)**, please specify:

_____

List **any remedies, supplements, vitamins or herbs** you are taking **and when** you started taking it:

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

DENTAL HISTORY

Have you got:

Bleeding gums? ☐ No ☐ Yes

Amalgams (silver fillings)? ☐ No ☐ Yes If yes, how many? ____

Root canal procedure done? ☐ No ☐ Yes If yes, how many? ____

Paradentosis (receding gums)? ☐ No ☐ Yes

If any other dental work has been done, please list:

_____ age: ____

_____ age: ____

_____ age: ____

ALLERGIES/SENSITIVITIES/DEFICIENCES/TOXICITIES

Do you have any **medically confirmed** allergy? ☐ No ☐ Yes

If yes, please list: _____

Does **any** other substance trigger the experience of allergy-like symptoms? ☐ No ☐ Yes

If yes, please list: _____

Do you have any food cravings? ☐ No ☐ Yes

If yes, please list: _____

Have you been exposed to any of the following:

Agricultural chemicals? ☐ Yes ☐ No

Industrial/workplace chemicals? ☐ Yes ☐ No

Cigarette smoking? ☐ Yes ☐ No How much? _____ How long? _____

Alcohol use? ☐ Yes ☐ No How much? _____ How long? _____

Recreational drugs? ☐ Yes ☐ No How much? _____ How long? _____

Other, please explain: _____

SELF- ASSESSMENT

Please list chronologically the **events** in your life that have had a **major psychological impact** on you and give your **age** when they occurred.

	Age		**Age**
1. _____	____	7. _____	____
2. _____	____	8. _____	____
3. _____	____	9. _____	____
4. _____	____	10. _____	____
5. _____	____	11. _____	____
6. _____	____	12. _____	____

My major positive and negative **characteristics** are **(+)** _____ **(-)** _____

My repetitive **dream** is**:** _____

My deepest **fear** is: _____

My **hobbies include:** _____

Other **relevant information** that you feel like conveying at this point:

_____

_____

Stress Management

Please **tick the most frequent trigger** of your stress:

Relationships with ☐ *Money* ☐ *Job security*

Other(s) – please specify*:* _____

Please **tick one or more of the physical signs** of your stress**:**

☐ *Tiredness* ☐ *Headaches* ☐ *Neck ache* ☐ *Backache* ☐ *Chest pains*

☐ *Palpitations* ☐ *Digestive problems* ☐ *Frequent urination* ☐ *Loss of Libido* ☐ *Period problems*

☐ *Frequent infections* ☐ *Sleep problems* ☐ *Weight gain/loss* ☐ *Excessive sweating*

Other(s) – please specify:_____

Please **tick one or more of the psychological signs** of your stress:

☐ *Moodiness* ☐ *Apathy* ☐ *Depression* ☐ *Anxiety* ☐ *Frustration*

☐ *Indecision* ☐ *Boredom* ☐ *Guilt* ☐ *Poor concentration*

☐ *Aggressiveness* ☐ *Clumsiness*

Other(s) – please specify: _____

Please **tick one or more of the behavioural signs** of your stress:

☐ *Being accident-prone* ☐ *Addictions (alcohol, drugs, smoking, tea, coffee)*

☐ *Withdrawal* ☐ *Conflict making* ☐ *Absenteeism*

Other(s) – please specify: _____

Please draw **two pictures** that represent:

1. My Health condition

2. My ideal life

Name and contact telephone number of **your GP:** _____

Name and contact telephone number of **your dentist:** _____

How did you hear about us? _____

PAYMENT METHOD

Please note that **settlement of all accounts remains your responsibility** and not any third party. The fee of **£160 is payable after the treatment**.
Full fee will be charged for any cancelled or broken appointment **without prior notice of 24 hours**.

I confirm that I accept responsibility for all charges due for the Biomedic services provided.

Signature of patient/ parent/ guardian _____ Date: _____

THANK YOU

PRINT
and bring on appointment
to Biomedic doctor

WELCOME TO BIOMEDIC