Patient Medical Questionnaire

# **Personal Details**

**Name:**

**Date of Birth:**

**Home Address:**

**Telephone No.**(Home):

**Telephone No.**(Mobile):

**Email Address:**

**Patient Next of Kin Details:**

**Name:**

**Relationship:**

**Home Address:**

**Phone:**

**Email:**

### **Medical history**

What reasons are you seeking I.V treatments ( Please Tick what applies to you )

Illness: (please describe)

Body & Hair: (Please describe what conditions you are wanting to address)

Serious Illness (please describe illness)

Immunity Boost (Have you recently been sick with a cold, flu, virus)

**What treatments and/or surgeries have you had for any medical illness or any cancer?**

**If you currently have Cancer What side effects (if any) are you experiencing from your current treatment?**

**What Treatments have you received Chemo? Radiation Treatment?**

**Are you currently receiving any Treatment for your cancer?**

**Current Medications (please list all including any supplements):**

**Medications:**

**Supplements:**

**Are you taking Aspirin, Ibuprofen or any other anti-inflammatories (including steroids)?** (Yes, No)

*If “Yes” is selected,* **please specify:**

**Have you ever suffered from bleeding episodes or peptic ulcer disease?** Radio (Yes, No)

**Have you ever suffered from serious heart, liver, or kidney disease?** Radio (Yes, No)

**Non-Cancer Past Medical History?**

**What Operations have you had in the past?**

**Year of Operation if known:**

**Any known Allergies to any medications?**

***Food Allergies?***

***Vitamin Allergies?***

# **Medical Correspondence**

***Should you proceed with I.V Treatment at Boost I.V, written correspondence following appointments with your doctor will be sent to you electronically (via the Patient Portal and/or email). Boost I.V Ltd recommends that you share this correspondence with your GP. Should you wish the clinic to correspond directly with your GP and/or oncologist, please enter details below, ensuring email addresses and telephone numbers are complete and correct.***

**GP Details**

**GP Name:**

**Surgery Name & Address:**

**Surgery Email:**

# **Oncologist Details**

**Oncologist Name:**

**Oncologist Facility Name:**

**Oncologist Secretary Email:**

Phone Number:

# **COVID-19**

**Have you experienced any of the following symptoms within the last 14 days?**

**Temperature or feeling feverish?** Yes / No

**New cough?** Yes / No

**Shortness of breath?** Yes / No

**Flu-like symptoms such as fatigue, headache, muscle pains?** Yes / No

**Loss of taste or smell?** Yes / No

**Have any of your family members or immediate close contacts experiencing any of the above symptoms?** Yes / No

*If “Yes”* **when?**

**Have you or any of you family members or immediate close contacts travelled within UK or attended a public event in the last 14 days?** Yes / No

*If “Yes”* **where and when?**

### **Confirmation**

**Please confirm that you have read & are happy to sign The Boost I.V Consent Form and are happy to proceed with your initial consultation** Yes / No