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

CONFIDENTIAL- FOR MEDICAL PURPOSES ONLY

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.	________________________________	_____

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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:

____

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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: ______________________________

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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:

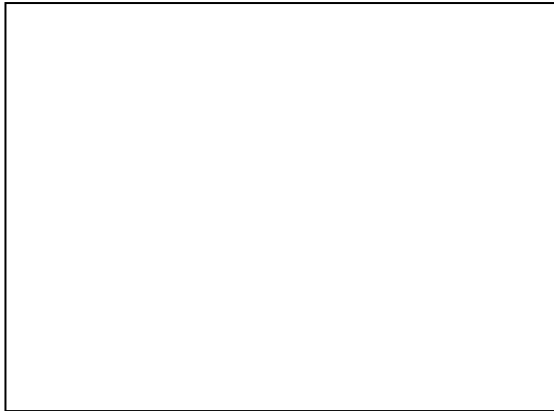
Being accident-prone *Addictions (alcohol, drugs, smoking, tea, coffee)*

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 th ird party. The fee **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

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