FILE NUMBER:		
FILE INDIVIDER.		

MEDICAL INFORMATION & HISTORY						
NAME: TEL NO: LENGTH:		ID NO.: DATE OF BIRTH (DOB): WEIGHT:				
*** THIS FORM MUST BE COMPLETED IN ENGLISH AS THE PROGRAM IS WRITTEN BY OUR DOCTORS IN AMERICA *** **** COMPLETED DISCLAIMER MUST BE MAILED TO MEDICAL@JOHS.CO.ZA ****						
MEDICAL HISTORY SECTION						
For treatment of any conventional medical conditions as listed in the fourteen bodily systems below. Please be thorough and check <u>each system</u> either YES or NO. Provide details of the <u>MOST</u> important medical conditions, complaints or illnesses in every section where YES is indicated in the space provided after the 14 listed bodily systems. Circle the condition you have at every number. <u>VERY IMPORTANT:</u> List only your own, <u>current</u> and most urgent medical conditions needing treatment. DON'T include family history and only mention your own history for the past 10 years if it relates to your current condition(s). Please also list any currently used acute or chronic medications (if you don't remember the name(s) at least indicate what the medication is used for).						
Do you <u>CURRENTLY</u> have, or suffer from, any of the following?	•					
1. HEART AND CIRCULATION CONDITIONS YES	NO	2. MENTAL HEALTH	YES NO			
Example: chest pain (angina), abnormal heartbeat, high blood pressure (hypertension), heart valve replacement, congenital (born with) heart disease rheumatic fever, high cholesterol, previous heart surgery (stents, pacemaker)		Example: mood disorders (depression, bipolar disorder), anxiety disorders, schizophrenia, sleeping disorders (e.g. narcolepsy), Alzheimer's disease, autism, attention deficit-hyperactivity disorder (ADHD), drug and/or alcohol abuse. Bulimia/anorexia.				
3. TUMOURS AND GROWTHS YES	NO	4. METABOLIC OR ENDOCRINE CONDITIONS	YES NO			
Example: cancerous skin lesions (basal cell or squamous cell carcinomas), b disease (cysts/fibromas/infections), breast lumps, non-cancerous or canceroutumours, malignancies or metastatic cancer (as medically diagnosed).		Example: diabetes I or II (specify which type!), thyroid disease, pituitary gland, osteoporosis, growth deficiency, metabolic disorders, congenital defects, hormonal abnormalities.				
5. GYNAECOLOGICAL & OBSTETRIC CONDITIONS YES	NO	6. ABDOMINAL CONDITIONS	YES NO			
Example: cervix conditions (CIN or infections), abnormal/painful/heavy mens bleeding, endometriosis, polycystic ovarian syndrome, infections/discharge, opathology (cysts, absent after hysterectomy), uterus abnormalities.		Example: hepatitis, liver cirrhosis, alcoholic liver disease, liver failure, pancreatitis, pancreas disorders (insulin abnormalities), gall stones, heartburn and reflux, hernias (diaphragm/umbilical/groin), ulcers, inflammatory bowel diseases (Crohn's disease, ulcerative colitis).				
7. BRAIN AND NERVE CONDITIONS YES	NO	8. BLOOD AND CIRCULATION CONDITIONS	YES NO			
Example: stroke, brain bleeding (aneurism), epilepsy, motor neuron disease, myasthenia gravis, migraine and headaches, Parkinson's, disease, spinal co paraplegia (lameness), blackouts (transient ischemic attacks). Speech abnor	rd injury,	Example: deep vein thrombosis, anaemia, ITP (platelet deficiency), blood clotting diseases, leukaemia, lymphoma, pulmonary embolus, haemophilia and other bleeding disorders, varicose veins, spider veins (telangiectasia).				
9. BREATHING AND RESPIRATORY CONDITIONS YES	NO	10. EYE CONDITIONS	YES NO			
Example: asthma, chronic obstructive pulmonary disease (emphysema, chrobronchitis, bronchiectasis), interstitial lung diseases, tuberculosis and other cinfections, sarcoidosis, pneumonia		Example: cataract (only if currently present), keratoconus, corneal ulcer, uveitis, glaucoma, squint, any abnormality of eyelids, retinopathy, macular degeneration, cornea transplant, eye surgery, blindness (partial or full), retinal detachment.				
11. MUSCULOSKELETAL (BACK, BONE & MUSCLE) YES	NO	12. EAR, NOSE, THROAT (ENT) & DENTISTRY CONDITIONS	YES NO			
Example: ongoing back pain, scleroderma, dermatomyositis, sarcoidosis, fibromyalgia, degenerative disc disease, scoliosis, kyphosis, spinal column/vcconditions, gout, fractures (only at present), physical disability.	ertebral	Example: chronic otitis media (middle ear infection), chronic otitis externa, hearing problems (specify), hearing aid, cochlear implant, tonsillitis, adenoiditis, deafness, nasal surgery, dental treatment or dental surgery (specify).				
13. KIDNEY OR URINARY CONDITIONS YES	NO	14. MALE UROGENITAL CONDITIONS	YES NO			
Example: kidney and/or renal failure, kidney stones, recurrent urinary infection polycystic kidney disease, urinary incontinence, bladder infections, other blackidney problems.		Example: prostate disorders (abnormal PSA, prostatitis), urogenital defects, varicocele, tumours, undescended testes, phimosis, urinary incontinence, erectile dysfunction/impotence.				
15. IS ONE OF YOUR SHOULDERS LOWER THAN YES	NO	16. DO YOU HAVE ABDOMINAL / BELLY FAT? NO	MODERATE			
THE OTHER (DROOPING SHOULDER)		EXCESSIVE	FXTREME			

** 1) PLEASE DESCRIBE FULLY ANY YES ANSWERS GIVEN ON PAGE 1. KEEP IN MIND THAT YOUR MORE SERIOUS AILMENTS WILL BE GIVEN TOP
PRIORITY WHEN THE PROGRAM IS WRITTEN.
** 2) PLEASE LIST ANY ALLERGIES YOU MIGHT HAVE (FOR EXAMPLE: PENICILLIN)
DDOODAM DECION
PROGRAM DESIGN COMBINE analysis results with Medical History. Conditions listed in the Medical History section have preference, focus on acute but also mention chronic diseases AND
MARK - If applicable
INCLUDE my relevant medical pathology, lab % other test results comprising of pages (included with this Disclaimer)
ADD more pages if needed including Name & Date of Birth - Amount of pages added when mailed to medical advice HUB
Kindly note that any program produced MUST be applied daily for a minimum period of two weeks fo acute (recent) conditions and up to six months (26 weeks) for chronic and
serious long term illnesses. Compliance is of the utmost importance in conjuction with balanced lifestyle choices.
I, the undersigned, hereby agree and confirm the following as set out herein. The information and programs written are not intended to serve as substitutes for professional medical advice, diagnosis or treatment. Nor should they be used against your GP's advice or in place of your usual established medical care and/or medications. NEVER disregard professional medical advice, or delay in seeking it, because of information or program(s) received from the Institution of Health Science. Medication should also be used / reduced / increased only as per your doctor's advice. If you think you may be suffering from any medical condition, you should seek immediate medical attention. Institution of Health Science and their employees are not responsible or liable for any harm or injury to you following any advice, course of treatment, diagnoses or from any information or program that you obtain from us. The Institution of Health Science will keep any information, including personal information relating to yourself, supplied to us in this application, or collected from other sources, confidential. You agree to us processing and disclosing your personal information in the following manner:- we may collect, collate, process, store and disclose your personal information to profile and analyse risk and, if necessary, to forward this information to a contracted third party in order to provide a wellness service to you. You hereby agree that the frequency protocol / program written on your behalf is based on information given by you and that it's purpose is to assist with established treatment procedures and in no way constitutes a medical diagnosis, treatment and/or substitution of your usual medical care. I will also adhere to terms and conditions as described on the website.
SIGNATURE DATE