

MEDICAL INFORMATION & HISTORY

NAME: _____ ID NO.: _____
 TEL NO: _____ DATE OF BIRTH (DOB): _____
 LENGTH: _____ 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@IOHS.CO.ZA ****

PROGRAM DURATION DESIGN

Please tick your desired option chosen and complete the hours needed

	Day program	Hours per day	R400 per program	
	Night program	Hours per night	R400 per program	
	Generic	N/A	R200 per program	

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 for acute (recent) conditions and up to six months (26 weeks) for chronic and serious long term illnesses. Compliance is of the utmost importance in conjunction 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.

MEDICAL HISTORY SECTION

For treatment of any conventional medical conditions as listed in the fourteen bodily systems below. Please be thorough and check **each system** either **YES** or **NO**. Provide details of the **MOST** 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. **VERY IMPORTANT:** List only **your own, current** 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 **CURRENTLY** have, or suffer from, any of the following?

1. HEART AND CIRCULATION CONDITIONS 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).

4. MENTAL HEALTH YES NO

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.

2. TUMOURS AND GROWTHS YES NO

Example: cancerous skin lesions (basal cell or squamous cell carcinomas), breast disease (cysts/fibromas/infections), breast lumps, non-cancerous or cancerous tumours, malignancies or metastatic cancer (as medically diagnosed).

5. METABOLIC OR ENDOCRINE CONDITIONS YES NO

Example: diabetes I or II (specify which type!), thyroid disease, pituitary gland, osteoporosis, growth deficiency, metabolic disorders, congenital defects, hormonal abnormalities.

3. GYNAECOLOGICAL & OBSTETRIC CONDITIONS YES NO

Example: cervix conditions (CIN or infections), abnormal/painful/heavy menstrual bleeding, endometriosis, polycystic ovarian syndrome, infections/discharge, ovarian pathology (cysts, absent after hysterectomy), uterus abnormalities.

6. ABDOMINAL CONDITIONS YES NO

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).

