MitoDynamics
Self Heal

Heart Rate Variability (HRV)
MEDICAL HISTORY

Date	
Name	
Address	
Contact Telephone Number/s	
Email Address	
Do you consent to occasional newsletters and clinic updates?	**Yes / No**
D.O.B	
Sex (male/female)	
Marital Status	
Religion	
Occupation	
Height	
Weight	
Name & Address of Primary Care Practitioner	
Who Referred you?	
Medical Diagnosis	

Date of Onset	
Treatment	
Outcome	
Previous Illnesses or surgery	
Allergies/Sensitivities (drug/food/supplement/chemical)	
Do you use recreational drugs? (yes/no)	
Do you use tobacco? (yes/no)	
Do you drink alcohol? (yes/no)	
Do you take contraceptive pill/HRT? (yes/no)	
Do you take blood thinning drugs? (yes/no)	
High Blood Pressure (yes/no)	
Low Blood Pressure (yes/no)	

Arthritis (yes/no)	
Cancer (yes/no)	
Diabetes (yes/no)	
Heart Disease (yes/no)	
Stroke (yes/no)	
Lung/Breathing Problems (yes/no)	
Digestive Problems (yes/no)	
Bladder/Bowel Problems (yes/no)	
Liver/Kidney Problems (yes/no)	
Headaches (yes/no)	
Bone Loss (osteoporosis) (yes/no)	
Circulation Problems (yes/no)	
Epilepsy/Seizures (yes/no)	
Eye problems (yes/no)	
Ear Problems (yes/no)	
Eating Disorders (yes/no)	
Gout (yes/no)	
Sinus/Respiratory Problems (yes/no)	
HIV/AIDS (yes/no)	
Hormonal Problems (yes/no)	
Thyroid Disease (yes/no)	
Muscle problems (yes/no)	
Skin Problems (yes/no)	
Weight Gain/Loss	

(yes/no)	
What exercise do you do?	
What are your health goals?	

Please list current medications and/or food supplements below and include any relevant additional information below: