**Medical History & Informed Consent Form for Intravenous Nutrient Therapy (IVNT) for Non-medicinal Indications**

## This is your medical history form, to be completed prior to your first Intravenous Nutrient Therapy (IVNT) session. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin the supplementation program.

This form is extensive, but please try to complete it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a supplementation that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Emergency Contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## GP/Consultant

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## I ***give/do not give*** my permission to inform my GP about the Intravenous Nutrient Therapy (IVNT) that I am about to receive.

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Location: Kat & Co Aesthetics, Birmingham.

Gender

Male Female

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your purpose for having this intravenous nutrient therapy (IVNT)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any IVNT before?

Yes No

Are you scared of needles/needle phobic?

Yes No

Do you faint easily when you have blood taken?

Yes No

## Women only answer the following:

*Check those questions to which you answer yes (leave the others blank).*

Any menstrual period problems?

Are you pregnant?

Significant childbirth - related problems?

Are you breastfeeding?

Urine loss when you cough, sneeze or laugh?

Are you on any type of hormone replacement therapy?

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Men only answer the following:

*Check those questions to which you answer yes (leave the others blank).*

Do you have Prostate problems?

Do you have Erectile dysfunction?

Are you taking hormone replacement i.e. testosterone?

When was your last PSA blood test?

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Men and women answer the following:

List any prescription medications you are now taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any self-prescribed medications, dietary supplements, or vitamins you are now taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last complete physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Normal Abnormal Never Can’t remember

Date of last electrocardiogram (EKG or ECG): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Normal Abnormal Never Can’t remember

List any other medical or diagnostic test you have had in the past two years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List hospitalizations, including dates of and reasons for hospitalisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any drug or other causes of allergies including seafood (shellfish): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Past medical history

*Check those questions to which you answer yes (leave the others blank).*

Heart attack if so, how many years ago? Rheumatic Fever

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Heart murmur

Diseases of the arteries

High blood cholesterol

Anaemia or other blood disorders i.e. Sickle Cell disease, Thalassemia

G6PD deficiency (glucose-6-phoshate dehydrogenase enzyme deficiency)

Varicose veins

Arthritis/Gout of legs or arms

Diabetes or abnormal blood-sugar tests

Phlebitis (inflammation of a vein)

Deep vein thrombosis/blood clot in the leg

Dizziness or fainting spells

Epilepsy or seizures

Stroke

Scarlet Fever

Infective endocarditis

Infectious mononucleosis

Nervous or emotional problems

Thyroid problems

Parathyroid problems

Adrenal gland problems

Pancreas/digestion problems

Stomach/duodenum ulcer

Pneumonia

Bronchitis

*Continue on next page*

Emphysema

Asthma or Hay fever

Abnormal chest X-ray

Other lung disease

Kidney disease

Broken bones/osteoporosis

Liver disease

Jaundice or gall bladder problems

Allergies including to shell fish

Leukemia or cancer

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Familial Diseases

*Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?*

*Check those questions to which you answer yes (leave the others blank).*

Heart attacks under age 50

Strokes under age 50

High blood pressure

Elevated cholesterol

Diabetes

Asthma or hay fever

Skin allergies

Congenital heart disease (existing at birth but not hereditary)

Heart operations

Red blood cell disorders i.e. Sickle Cell, Thalassaemia, Anaemia

Glaucoma

Kidney disease

Obesity (20 or more pounds overweight)

Leukemia or cancer under age 60

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Other heart disease risk factors

Have you ever smoked cigarettes, cigars or a pipe?

Yes No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Diet**

What do you consider a good weight for yourself? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the most you have ever weighed (including when pregnant)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old were you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My current weight is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

One year ag my weight was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At age 21 my weight was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever drink alcoholic beverages?

Yes No

*If yes, what is your approximate intake of these beverages?*

Beer

None Occasional Often If often, \_\_\_\_\_\_\_\_\_\_\_\_\_ per week

Wine

None Occasional Often If often, \_\_\_\_\_\_\_\_\_\_\_\_\_ per week

Hard Liquor

None Occasional Often If often, \_\_\_\_\_\_\_\_\_\_\_\_\_ per week

At any time in the past, were you a heavy drinker (consumption of six units of hard liquor per day or more)?

Yes No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## I have read and understood the purpose of this questionnaire.

1. I declare that the information given in this document is true and complete to the best of my knowledge, and I understand that false information or failure to disclose information may effect my health.
2. I was given the opportunity to ask questions and I have had enough time to reconsider.
3. I accept that further medical information may be requested from my doctor if needed

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Name: Dr Anahita Mansouri (Dr Ana)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Location: Kat & Co Aesthetics, Birmingham.

# Consent to Intravenous Nutrient Therapy (IVNT)

Before you choose to use the services of IVNT practitioner: Dr Anahita Mansouri (Dr Ana) please read the following information FULLY AND CAREFULLY:

# Why Intravenous Nutrient Therapy (IVNT)?

## The main benefits may include:

1. Injectable micronutrients are not affected by stomach, or intestinal absorption problems
2. Total amount of infusion/injection is available to the tissues.
3. Nutrients are forced into cells by means of a high concentration gradient.
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had an opportunity to receive such information and to give my informed consent.

***GOAL***: The basic goal is to encourage people to become (1) knowledgeable about and responsible for their own health, (2) and to bring it to a personal optimum level, (3) to delay the aging process and to (4) enhance their metabolism.

INTRAVENOUS NUTRIENT THERAPY (IVNT) is designed to improve your optimum health, absent of other non-nutritional complicating factors, and requires a sincere commitment from you, possible lifestyle changes, and a positive attitude.

**Caution:** *It is not intended to make a medical diagnosis and to recommend any medicinal treatment(s). No comment or recommendation should be construed as inferring or implying a medical diagnosis.*

Since every human being is unique, we cannot guarantee any specific result from INTRAVENOUS NUTRIENT THERAPY (IVNT) protocols and programmes. Medication and or medical conditions may have a negative impact on the positive effects of IVNT.

***HEALTH CONCERNS***: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider such as your GP or Consultant. If you are under the care of another healthcare provider, it is important that you inform your other healthcare providers of your use of nutritional supplements.

**Note:** *Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.*

If you are using medications of any kind, you are required to alert IVNT practitioner Dr Anahita Mansouri (Dr Ana) to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

**Note:** *If you have any physical or emotional reaction to IVNT, discontinue use immediately, and contact your IVNT PRACTITIONER to ascertain if the reaction is adverse or an indication of the natural course of the body’s adjustment to the supplementation.*

Laboratory testing will be done to determine areas of dysfunction, not to diagnose or treat. Lab testing can assist in revealing nutrient deficiencies and weaknesses, however in many cases nutrient blood tests are not a true reflection of body tissue levels.

However, although blood tests do not accurately reflect the nutrient status of nutrients in body tissues outside of the blood stream, certain blood tests are necessary to ascertain if vital organs are functioning normally. Below is a list of blood tests that are necessary even in healthy individuals.

Essential blood tests:

1. Full blood count
2. Liver function test
3. Kidney Function Tests
4. G6PD enzyme (Required in selected patient groups only, mandatory for Skin Brightening therapy)

Patients with any of the following ancestry are at higher risk of G6PD (glucose-6-phoshate dehydrogenase) enzyme deficiency and therefore require this additional blood test as a one off during the initial consultation to ensure they are safe to metabolise IV nutrients:

* + - Jewish
    - Mediterranean
    - African
    - Asian
    - New Guinea

I confirm that the above listed ancestry criteria **do not apply** to me

I confirm that the above listed ancestry criteria **do apply** to me and I accept the extra blood test with an additional one-off cost of £40

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## ***COMMUNICATION***: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products required to correct possible imbalances. It is your responsibility to do your part by following healthy dietary guidelines, exercise your body if possible, get plenty of rest, and learn more about Nutrient health benefits.

You should request your other healthcare provider, if any, to feel free to contact IVNT practitioner Dr Anahita Mansouri (Dr Ana) for answers to any questions they may have regarding nutritional therapy.

***I understand that***:

## The procedure involves inserting a needle into a vein and injecting the selected IVNT protocol

1. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes
2. Several supplementation sessions may be required
3. Risks of intravenous therapy include but not limited to:
   1. Occasionally to commonly: discomfort, pain and bruising at injection site
   2. Rarely: inflammation in the vein used, phlebitis, metabolic disturbances
   3. Extremely rarely: severe allergic reaction, anaphylaxis, systemic infection, cardiac arrest and possible death

I am aware that other unforeseeable complications could occur. I do not expect Dr Ana (Anahita Mansouri) to anticipate and or explain all risk and possible complications. I rely on them to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. ***At any stage during the infusion/injection, I have the right to request that the procedure is terminated, however I accept that I will not be re-imbursed once supplementation has commenced.***

My signature on this form affirms that I have given my consent to an ***Intravenous Nutrient Therapy (IVNT)*** protocol as specified below:

|  |  |
| --- | --- |
| IV Cocktails or Formulas | Sessions |
| Modified Myers Plus |  |
| Performance Booster |  |
| Amino Muscle Plus |  |
| Fat Burner Plus |  |
| Immuno Booster |  |
| Skin Brightening |  |
| ATP-Energiser |  |
| Customised Protocol |  |

|  |  |
| --- | --- |
| All-in-one Booster Shots | Sessions |
| Glutathione IV Booster Shot |  |
| Vitamin B-12 IV/IM Booster Shot |  |

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Name: Dr Anahita Mansouri (Dr Ana)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Location: Kat & Co Aesthetics, Birmingham.

Session 6

Session 5