***AnnLynnsolutions Ltd***

***Cheshire Lasers***

***The Acorns***

***85, Wheelock Street***

***Middlewich***

***CW10 9AE***

***annlynnsolutions@gmail.com***

**Personal Information and Declaration Form**

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| --- |
| IF YOU NEED HELP FILLING IN THIS QUESTIONNAIRE PLEASE CALL |
| 07305815388 OR 07305677365 TO BE GIVEN ASSISTANCE |

|  |  |
| --- | --- |
| **First Name/Names** |  |
| **Surname** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **1st Line of Address** |  |
| **Town** |  |
| **County** |  |
| **Post Code** |  |
| **Contact Details**  | **Telephone Number:****Email Address:** |
| **Contact in Case of Emergency** |  |

|  |  |
| --- | --- |
| **Name of GP** |  |
| **Name of Surgery** |  |
| **1st Line of Address** |  |
| **Town** |  |
| **County** |  |
| **Post Code** |  |
| **Contact Details** |  |

|  |  |
| --- | --- |
| **Do you class yourself as having a disability?** | **NO** |
|  | **YES (Please expand)** |

**FOR WOMEN ONLY:**

**Are you trying or planning a pregnancy in the near future? YES/NO**

**Are you or could you be pregnant? YES/NO**

**Are you breastfeeding? YES/NO**

**Are you on any Hormone Replacement Therapy? YES/NO**

**PRE EXISTING/PAST MEDICAL CONDITIONS: Please tick the following boxes if you have a history or new diagnosis of any of the following – please add anything you think you need to tell us……………………..**

|  |  |
| --- | --- |
| **Any form of Cancer** |  |
| **History of high cholesterol**  |  |
| **Sleep Apnoea** |  |
| **Medullary Thyroid Cancer or any thyroid disease/problems** |  |
| **Liver Problems (including hepatitis, fatty liver, alcoholic liver disease, liver failure)** |  |
| **Pancreatitis (acute/chronic)** |  |
| **Gallstones or any gallbladder disease** |  |
| **Diabetes or abnormal blood sugar tests** |  |
| **Inflammatory Disease (Chronic disease of Ulcerative Collitis)** |  |
| **Severe reflux/ stomach/ duodenum or gastric ulcer** |  |
| **Heart Disease (such as heart attack, rheumatic fever, irregular heart rate, angina)** |  |
| **An Eating Disorder** |  |
| **Skin conditions such as psoriasis** |  |
| **Mental Health Issues (including diagnosis of depression/anxiety)** |  |
| **Any Neurological Problems** |  |
| **Alcohol or Drug related problems** |  |
| **Any Bowel or Gastric related problems including history of Gastric Surgery ie Gastric Banding, Gastric Sleeve** |  |
| **Kidney problems including Chronic Kidney Disease** |  |
| **Anaemia or other Blood Disorders** |  |
| **None of the above** |  |

**Have you a family history of:**

**Medullary Thyroid cancer YES/NO**

**Multiple Endocrine Neoplasia Syndrome Type 2 YES/NO**

|  |  |
| --- | --- |
| **Height**  |  |
| **Weight**  |  |
| **BMI (if known)** |  |
| **Blood Pressure (if known)** |  |

**Have you been referred to another Specialist Service or Practitioner for a new or ongoing health complaint? YES/NO**

**Are you currently awaiting any Consultation/Surgery/Investigative Procedure?**

 **YES/NO**

**If YES please give detail below**

**…………………………………………………………………………………………………**

**………………………………………………………………………………………………….**

**Date of last physical examination if applicable……………………………………………...**

**Do you take any regular medication? Please tick below**

|  |  |
| --- | --- |
| **YES** | **NO** |
|  |  |

|  |
| --- |
| **Please list any medication that you are either prescribed or that you buy from over the counter** |
|  |
| **Do you have any known allergies? Please list below** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Do drink alcohol?**  | **YES** | **NO** | Units per week |
| **Do you smoke****Do you use E-cigarettes** | **YES****YES** | **NO****NO** | How many per day?CigarettesTobacco |

|  |
| --- |
| **How much activity do you have a day? Please describe**  |
|  |

|  |
| --- |
| **If you have tried to lose weight before, please list/describe what you have tried. Also please list any medication you have tried – either prescribed or over the counter** |
|  |

**Do you eat 3 meals a day?**

|  |  |
| --- | --- |
| **YES**  | **NO** |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How many calories do you think you eat in a typical day? Please tick** | Less than 800 | Between 800 and 1200 | Between 1200 and 2000 | More than 2000 |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **If you are to commence treatment with AnnLynnsolutions are you happy for us to inform you GP. Please tick** | **YES** | **NO** |

**IMPORTANT – IN ADDITION**

To enable a us to do a full assessment on your suitability for this treatment could you please bring with you a record of the following blood tests (we will be happy to contact the GP on your behalf if you have not got this information)

**Cholesterol – including full break down**

**Urea & Electrolytes (U&E’s)**

**Thyroid Function Tests (TFTs)**

**Diabetes Test (HbA1c/IFCC)**

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| --- | --- |
| **If you would prefer to see a male for your consultation, please tick this box** |  |

**Thank you for filling in this Health Questionnaire**

**Always Seek Medical Professional Advice Before Taking Prescribed Medication**

**AnnLynnsolutions will assess the information regarding the suitability of a consultation – we will then contact you by phone to either….**

1. **Invite you to make an appointment (when making the appointment we will ask for a non-refundable deposit of £50 which is deducted from your final invoice)**
2. **Advise if further information is needed before committing to an appointment**
3. **Advise you if we do not think we can offer injectable therapy**

**DECLARATIONS**

|  |  |  |
| --- | --- | --- |
| Do you understand that it is not safe to buy weight loss treatments from more than one provider at a time. In doing so you put your health at risk, and this would be against our professional advice. Please tick | **YES**  | **NO** |

|  |  |  |
| --- | --- | --- |
| Do you understand that this treatment has to be used in conjunction with a reduced calorie diet and increased activity for the best results. Please tick | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| Can you confirm that you have been truthful with your responses to the above questions, and that you have provided full details of all know medical conditions you have or have had in the past. Please tick | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| Can you confirm that you understand that no guarantees for weight loss can be given. Results may vary from individuals – depending on a variety of factors. Please tick | **YES**  | **NO** |

|  |  |  |
| --- | --- | --- |
| If the information on this form successfully completes our assessment criteria do you agree to a consultation with AnnLynnsolutions. Please tick | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| Please indicate that you consent to treatment for weight loss management which could involve injectable treatment. Please tick | **YES** | **NO** |

|  |  |  |
| --- | --- | --- |
| Are you happy for AnnnLynnsolutions to email you any details of promotions they may have available? Please tick | **YES** | **NO** |
|  |  |

**WE ARE UNABLE TO SHIP MEDICATION TO CLIENTS OUTSIDE OF THE UK**

AnnLynnsolutions confirm that this form is GDPR compliant. The sensitive information about your health is used to assess your suitability for medication and the weight loss programme offered.

The information is covered by our Privacy Policy this shows how we protect and manage your information – on addition we are governed by the Nursing and Midwifery Council, the Royal College of Nursing and the Care Quality Commission.

**SIGNATURE ……………………………………………. (electronic accepted)**

**DATE……………………………………………………**

**WE WILL NEVER SELL YOU INFORMATION TO A THIRD PARTY**