Science Fact – Not Science Fiction

Patient Name: ……..
D.O.B: ……..……...

NovoTHOR Medical History Questionnaire

Please ✓ box and underline or write in the box as appropriate.

Past medical History	Yes ✓	No ✓
Current Medications: please list		
Have you been told to stay out of the sun due to medication you take?		
Do you suffer from **Claustrophobia**		
Are you **pregnant** or **trying to get pregnant?** (If unsure, pregnancy test required)		
Have you undergone an **organ transplant**?		
Have you received a **steroid injection** within the last 3 weeks?		
History of **heart** conditions		
History of **epilepsy**		
Cancer 1) have you ever received a diagnosis of **cancer or metastatic disease**?		
Cancer 2) if you have answered 'Yes' to the question above, are you currently receiving treatment or are you on active surveillance?		
Do you have any of the following symptoms? - Visual disturbance, difficulty swallowing, speaking or walking, dizziness, fainting, nausea or numbness. - Severe low back pain +/- sciatica, bladder or bowel dysfunction, numbness or altered sensation in the buttocks or between the legs, sexual dysfunction, or progressive weakness in the legs and/or feet.		
Eyes/ears/nose/throat e.g. Macular degeneration		
Dermatological/skin conditions e.g. Eczema, Psoriasis, Acne		
Do you have any diagnoses not covered by the above?		
Please Note: **If any of the above information changes, please make us aware immediately.**		

I am hoping for help with the following symptoms and/or conditions: