PATIENT CONSULTATION FORM

Contact Details & Health History	
Full Name:	Tel:
Gender:	Email:
DOB:	Address:
Occupation:	
Date:	
Current Medication:	
Allergies:	
Any Past Serious Illnesses:	
Any Family Illnesses:	

Which HINNAO products are you interested in?

- ☐ Glutathione
- ☐ NMN
- ☐ Vit D3 + K2
- ☐ Turmeric Curcumin
- ☐ NAD+
- ☐ Resveratrol
- ☐ B12
- ☐ Anagen

What are your goals for supplementation? *(select all that apply)*

- ☐ Anti-ageing
- ☐ Increase Energy
- ☐ Hormone Balance
- ☐ Build Immunity
- ☐ Increase Libido
- ☐ Hair Rejuvenation
- ☐ Menopause
- ☐ Inflammatory Issues
- ☐ Prevent Ill-health
- ☐ Mood and Mind
- ☐ General Wellbeing
- ☐ Improve Skin Quality
- ☐ Joint Pain / Muscle Aches
- ☐ Support Heart Health
- ☐ Other:

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Is there anything of concern that has been raised by yourself or your doctor that we should know about?	
Are you a smoker?	☐ Yes ☐ No
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Would you be interested in a Health and Lifestyle Home Blood Test Kit to check your Vitamin B12, Vitamin D, Magnesium, Ferritin, TB12, HsCRP, Uric acid? This test will also measure your Inflammatory status.	☐ Yes ☐ No
Would you be interested in an Epigenetic Test to measure your biological age?	☐ Yes ☐ No
Patient Signature:	