



## Personal Information - Medical Questionnaire

Mr.  Mrs.

Last name

First Name

Identification Number

Date of Birth

Street

Zip Code

City

Country

Telephone

Mobile

Email

Desired First Appointment Date

Desired Treatment

- Assessment and Screening  
 Individualized Cell Therapy

- Detox Programme  
 Vitalization programme

Other

Desired Accomodation

Single

Double

Suite

Have you received any cell therapy before?

Yes

No

If yes, when and where did you receive the cell therapy?

What is your expectations for the desired treatment?

On basis of which problems are you aiming for the desired treatment?

Customer Signature: \_\_\_\_\_

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

## Medical Information

Do you take any medication?

Yes

No

Family medical history

Yes

No

Past illnesses

Yes

No

Have you ever had surgery?

Yes

No



Have you ever suffered from the following health problems? Please mark accordingly

**(Please tick / where applicable)**

- Low blood pressure    Systolic:
- High blood pressure    Diastolic:
- Bronchial Asthma
- Stroke
- General tiredness
- Insomnia
- Excessive need of sleep
- Diminution of mental efficiency
- Diminution of physical efficiency
- Failing memory
- Lack of concentration
- Premature Aging
- Stress
- Headaches
- Giddiness
- Migraine
- Decrease of potency
- Troubles of menopause
- Menstruation difficulties
- Weight increase
- Weight decrease
- Overweight
- Constipation
- Diarrhea
- Loss of appetite
- Excess appetite
- Psychiatric illness
- Nervous disturbances
- Depression
- Disturbances of blood supply (night)
- Heart and circulation disturbances

**Pains in joints or limbs**

- Shoulders
- Back or Neck
- Elbows
- Hand joints
- Knees
- Ankle Joints
- Spine column (cervical, thoracic, lumbar)

- Atherosclerosis
- Cramps in the legs
- Tiredness in the leg
- Varicose veins
- Swollen feet
- Swollen legs
- Rheumatism
- Digestive troubles (which)
- Stomach ulcer

**LiverAilments**

- Hepatitis, if yes, when?
- Jaundice, if yes, when?
- Gall-stones? Operated? When?

**KidneyAilments**

- Kidney stones? Operated? When?
- Nephritis (inflammation of)
- Nephrosis

**Do you pass urine with**

- Difficulty
- Time frequency
- Burning sensation

**Diabetes**

- Blood glucose level:

Other:

Allergies:

Remarks:

**Customer Signature**

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**Date**

**ZÉLL-V**