Secure Online Application Form

IBOGAINE UK

•Name

First

Surname

•Email

Phone *

•Cell Phone / Alternate Phone *

•Gender

•☐Male

•☐Female

•Height

•Weight

•Emergency Contact

First

Surname

•Your Home Address

Street Address

Address Line 2

City

State / Province & Region

••

Country

Afghanistan

Primary Drug Of Choice/Addiction

•Secondary Drug of Choice/Addiction

•Brief History Of Your Dependency & The Drug(s) Used Or Condition You Are Seeking Treatment For.

•Please Make Sure That You List All The Drugs & Medications That You're Using

•List of all non-prescribed medications / or illicit drugs used in the past 60 days.

•List of scripted medications you have but you're not currently not taking

•List of all supplements vitamins, workout enhancers nutricuticals .

•List of all foods medications you have intolerant or have allergic reactions too.

•List any injuries, accidents major surgeries Blood Transfusions Or Tropical Diseases You've Had

•Do you drink alcohol?

•☐Yes

•☐No

•If yes, how much and how often?

•Do you smoke?

•☐Yes

•☐No

•If yes, how much per day In Unit

•☐Yes

•☐No

•Do you have a history of seizures?

•☐Yes

•☐No

•If Yes Please Give a Detailed History About The Nature Of These Seizures Such As, Are They Related

•Do You Have a History Of Embolism, Blood clots Or Clotting Disorders Such As Heterozygous Factor 5 Leiden. Also, Have You Had in The Last 2 Years an Injury Where Blood Clots Resulted ?

•Do You Have Diabetes?

•☐Yes

•☐No

•If yes, which kind is it. Type 1 or Type 2?

•If Yes, Are You Insulin Dependent?

•☐ Type 1 Insulin Dependent

•☐Type 2 Non Insulin Dependent

•☐Type 3 Gestational (Pregnancy Induced)

•Do You Have Hypoglycaemia Or Get Unwell If You Miss Meals. If Yes, Please Explain.

•Do you have fainting spells or get dizzy upon getting up suddenly? If so, please provide details.

•Do you have a history of inflammatory bowel disease ulcerate colitis, Crohn's Disease, bleeding or peptic ulcers? If so, please provide details.

•Do you have any type of hepatitis, including abnormal liver function tests, hepatitis A,B or C, primary biliary cirrhosis, Hepatic Encephalopathy Elevated Ammonia or serum transaminases levels, etc
•If so, please provide us with full details.

•Do you consider yourself to be depressed Or Are You Being Treated For Depression?

•If So, Please Provide Us With Details.

•Have you Ever self Harmed, Attempted Suicide If So, Please Provide Us With Full Details.

•Have you ever been admitted to a psychiatric ward in a hospital? If so, please provide us with details.

•Do you have any type of acquired brain injury, neurological abnormalities Or Cerebellar Disorder?

If So, Please Provide Us With Details.

•Do You Have Asthma Or Respiratory Problems? If Yes, Do You Use An Inhaler?

•Do You Suffer From Or Have Any Of The Following Medical Conditions Please Check All That Apply.

•○Hepatitis A, B or C have you received interferon treatment

•○History of Ulcers Duodenal, Peptic, GI Tract etc

•○Slow Heart Rate (Bradycardia)

•○Fast Heart Rate (Tachycardia)

•○Problems With Your Thyroid (Hyper or hypo-thyroidism)

•○Heart Congenital Cardiac Disease

•○Respiratory Problems or Chronic Obstructive Pulmonary Disease (COPD)

•○Amenorrhoea Loss of Menstruation

•○Menorrhagia (Excessive Menstruation)

•○hyperprolactinemia

•○Pituitary Ademoma

•○Galactorroea

•○Back Problems including slipped disk & other injuries

•○Nausea

•○Dizzy Spells When Sitting or Laying (Supine)

•○Hypertension (High Blood Pressure)

•○Hypotension (Low Blood Pressure)

•○Orthostatic Hypotension (Dizziness When Standing Up)

•○Constipation or obstruction

•○Diarrhoea

•○Gastric Bleeding

•○Stomach problems Digestive Disorders

- ○ Hepatic Problems (Liver) or Disease
- ○ Seizures Drug related or epilepsy
- ○ Urinary Tract infections Or Frequency
- ○ Heart Problems palpitations Angina
- ○ Heart Burn
- ○ Painful Menstruation
- ○ Cancer
- ○ Fainting Passing Out
- ○ Numbness Such Or Raynaud's Syndrome
- ○ Diarrhoea
- ○ HIV Positive / Acquired Immunodeficiency Syndrome
- ○ Tremors/Spasms With Or Without Pain
- ○ Tuberculosis
- ○ Shortness of Breath
- ○ Hyper Ventilation (Breathing Fast)
- ○ Wheezing Cough Or Difficulties Breathing
- ○ Obesity
- Please Detail Any Other Symptoms Or Medical Conditions Not Mentioned On This Form

Submit