

Your Name	K
Date of Birth	01-03-1986
Phone	0834686254
Your Email	kayzedd@gmail.com
Location	Lagos
Please specify you gender?	Male
Are you overweight or obese?	Yes
Are you pregnant, possibly pregnant or breastfeeding?	No
Do you exercise regularly?	Yes
Do you face any of the following symptoms?	Pain
If Other, please specify	Back pain
Have you ever experienced the following scenarios?	Other
If Other, please specify	Pulled back muscle
Have you ever been diagnosed with Heart Attack and Heart Disease, Stroke and Brain Problems or Kidney Disease?	No
Are you currently taking any prescription, non prescription or illegal drug or herbal medication? and have you recently taken any medication in the last two weeks? please specify.	No
please specify if you have allergy to any medication or any other substance?	No
Please specify the name of preferred pharmacy where you want to collect your prescription/medications?	Chambers Pharmacy Glasnevin Dublin 9
I understand the side-effects and effectiveness of the above-mentioned treatment and I am giving consent to continue with my request.	I understand the side-effects and effectiveness of the above-mentioned treatment and I am giving consent to continue with my request.
I am confirming the treatment prescribed above will be for my personal use	I am confirming the treatment prescribed above will be for my personal use