

AIG. 20909160

Patient Intake Form

Name:	Mr. Uttam Kumar Roy	Ph Number	9832027754.
Address	West Bengal	Email	
Referred Doctor:	Self	DOB /Sex	46/M
Sample coordinator	Chechaultha	Date	31/12/2024.
		Pre Counselor	Iswarya

Current Complaints

Complaint 1: No headache on & off since 6 months

a. Onset Relieved Rx.

b. Duration No acute gen infection of liver 2 months ago

Complaint 2: _____

a. Onset Bloating, loose stools, incomplete evacuation

b. Duration piles +

Complaint 3: _____

a. Onset No palpitations on & off ass = burning sensation

b. Duration in (RT) hypochondriums.

Reason for Genetic Testing? No giddiness on standing after long sitting

Why do you want to do this genetic testing

- | | | |
|----|--|-------------------------------------|
| 1 | I want to know if there is any genetic cause for my Medical Condition. | <input checked="" type="checkbox"/> |
| 2 | I want to know if there is any genetic cause for a symptom I have been having since a long time. | <input checked="" type="checkbox"/> |
| 3 | My family or close relatives are having history of chronic disease. | <input type="checkbox"/> |
| 4 | There is a history of cancer in me/ history of cancer in the family. | <input type="checkbox"/> |
| 5 | Have a history of genetic disease in the immediate family or close relatives. | <input type="checkbox"/> |
| 6 | I want to know the future risks and possibilities regarding my health. | <input checked="" type="checkbox"/> |
| 7 | I want to check if we are carriers for any genetic illness. | <input type="checkbox"/> |
| 8 | I want to know treatment plans based on genetics for our illness. | <input checked="" type="checkbox"/> |
| 9 | I have received an abnormal prenatal screening test or Amniocentesis. | <input type="checkbox"/> |
| 10 | I want to do it because my other family members have taken genetic testing. | <input type="checkbox"/> |
| 11 | I want to know my Genetic makeup. | <input checked="" type="checkbox"/> |

Loss of Appetite, loss of memory - Acidity

Sleep - 11-8, no freshness after waking

Past Medical History

Asthma	<input type="checkbox"/>	Peptic Ulcer disease	<input checked="" type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Frequent Constipation	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Cerebrovascular Accidents/ Stroke	<input type="checkbox"/>	Migraines	<input checked="" type="checkbox"/>
Myocardial Infarction/ Heart Attack	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Kidney Stones	<input checked="" type="checkbox"/>	Arthritis	<input type="checkbox"/>
Frequent Sinus Infections	<input type="checkbox"/>	Psoriasis/Skin Conditions	<input type="checkbox"/>
Others	<input type="checkbox"/>		

oily & spicy foods → doesn't suit

Past Surgical History

Appendectomy	<input type="checkbox"/>	Joint Replacements	<input type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>	Cardiac Stent Placements	<input type="checkbox"/>
Coronary Artery Bypass Grafting (CABG)	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>
Splenectomy	<input type="checkbox"/>	Oophorectomy	<input type="checkbox"/>
Bariatric Surgery	<input type="checkbox"/>	Cholecystectomy	<input type="checkbox"/>
Others	<input type="checkbox"/>		

Family History

Condition		If Yes, which member of the Family
Allergies	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Asthma	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Depression/Suicide Attempts	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Premature Myocardial Infarction	<input checked="" type="checkbox"/>	Father <input checked="" type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Sudden Death	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
High Blood Pressure	<input checked="" type="checkbox"/>	Father <input checked="" type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Consanguineous Marriage	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cerebrovascular Accident	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Diabetes	<input checked="" type="checkbox"/>	Father <input checked="" type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Seizures	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Cancer	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Hearing/Speech Problems	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Liver Cirrhosis	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Connective Tissue Diseases	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>
Others	<input type="checkbox"/>	Father <input type="checkbox"/> Mother <input type="checkbox"/> Sibling <input type="checkbox"/> Other <input type="checkbox"/>

Mental Health History (Subjective)

Do you face any difficulty concentrating on your work?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Have you lost much sleep/difficulty sleeping?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are not playing a useful part in your work?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are under constant stress?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you could not overcome difficulties?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel unhappy or depressed most days of the week?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you feel you are losing confidence?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any stressors in family or professional life more than ordinary?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Do you consider yourself an anxious person?	Yes <input type="checkbox"/>	Sometimes <input type="checkbox"/>	No <input type="checkbox"/>
Details if Yes for any question above			

Sexual History

Women		
Menstrual Cycles	Regular <input type="checkbox"/>	Irregular <input type="checkbox"/>
History of Infertility	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Men		
Erectile Dysfunction	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Current and Past Medications

Please name the list of Medications being used currently

	Name of the Medicine	Dose	Frequency
1			
2			
3			
4			

Review of Systems

Constitutional	
Lack of Energy	<input type="checkbox"/>
Unexplained Weight Loss/Gain	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>
Fevers	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>
Cardiovascular	
Heart Racing/Palpitations	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>
Swelling of legs/feet	<input type="checkbox"/>
Pain in calf while walking	<input type="checkbox"/>
GU	
Painful Urination	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>

ENT	
Sinus Problem	<input type="checkbox"/>
Difficulty in Hearing	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>
Respiratory	
Shortness Of Breath	<input type="checkbox"/>
Prolonged Cough	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
Gastrointestinal	
Heartburn	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Intolerance to certain food	<input type="checkbox"/>
Diarrhea/ Loose Stools	<input type="checkbox"/>
Difficulty in Swallowing	<input type="checkbox"/>
Musculoskeletal	
Joint Pains	<input type="checkbox"/>
Aching Muscles	<input type="checkbox"/>
Swelling of Joints	<input type="checkbox"/>
Back pain	<input type="checkbox"/>

Skin	(-)
Itching	<input type="checkbox"/>
Persistent Rash	<input type="checkbox"/>
New Skin Lesions	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>
Excessive Hair	<input type="checkbox"/>
Neurologic	
Frequent Headaches	<input checked="" type="checkbox"/>
Double Vision	<input type="checkbox"/>
Weakness	<input type="checkbox"/>
Change in Sensation	<input type="checkbox"/>
Dizziness	<input checked="" type="checkbox"/>
Tremors	<input type="checkbox"/>
Episodes of Vision Loss	<input type="checkbox"/>
Endocrine	
Intolerance to Heat or Cold	<input type="checkbox"/>
Frequent Hunger or Thirst	<input checked="" type="checkbox"/>
Changes in Sex Drive	<input type="checkbox"/>
Allergic/Immunologic	(-)
Food Allergies	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>
Itching Eyes/ Sneezing	<input type="checkbox"/>
Frequent Infections	<input type="checkbox"/>

Personal History/Health

Do You Drink Alcohol?	Yes <input checked="" type="checkbox"/>	Previous Drinker <input type="checkbox"/>	Never <input type="checkbox"/>	
How Many Drinks Per Week? <i>1-2 times/ Month</i>	1 <input checked="" type="checkbox"/>	2 <input checked="" type="checkbox"/>	3 <input type="checkbox"/>	More Than 3 <input type="checkbox"/>
Do You Smoke Cigarettes	Yes <input type="checkbox"/>	Previous Smoker <input type="checkbox"/>	Never Smoker <input type="checkbox"/>	
If Yes, How Many Packets of Cigarettes Per Day? <i>1-2/day</i>	Less than 1 <input type="checkbox"/>	1 <input checked="" type="checkbox"/>	2 <input checked="" type="checkbox"/>	More Than 2 <input type="checkbox"/>
What is your wake up time	Before 6 am <input type="checkbox"/>	After 6 am <input type="checkbox"/>		
What is your go to bed time	Before 8 pm <input type="checkbox"/>	After 8 pm <input type="checkbox"/>		
Do You Workout	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>		
If Yes, How Many Times Per Week?	Less than 4 <input type="checkbox"/>	More than 4 <input type="checkbox"/>		
Any participation in active sport when young?	Yes <input type="checkbox"/>	Never <input type="checkbox"/>		

Diet

How many meals/day	Less than 3 <input type="checkbox"/>	3 <input checked="" type="checkbox"/>	More than 3 <input type="checkbox"/>	
How many times do you eat processed foods per week(Chips,Fried Items, Fast Food)?	None <input type="checkbox"/>	1 <input checked="" type="checkbox"/>	2 <input checked="" type="checkbox"/>	More Than 2 <input type="checkbox"/>
How many times do you eat outside food?	None <input type="checkbox"/>	1 <input checked="" type="checkbox"/>	2 <input checked="" type="checkbox"/>	More Than 2 <input type="checkbox"/>
How many times do you have soft/carbonated drinks per Week?	None <input checked="" type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	More Than 2 <input type="checkbox"/>

Physical Examination

- a. Blood Pressure: _____
- b. Pulse Rate: _____
- c. Height: _____
- d. Weight: _____
- e. BMI: _____

Blood Work

Mandatory Tests			
1		Complete Blood Count	<input type="checkbox"/>
2		Thyroid Profile	<input type="checkbox"/>
3		HbA1C	<input type="checkbox"/>
4		Liver Function Test	<input type="checkbox"/>
5		Kidney Function Test	<input type="checkbox"/>
6		Lipid Profile	<input type="checkbox"/>

Main issue is to gut

INFORMED CONSENT FORM

Name: Uttam Kumar Roy

Date: 31/12/24

DOB:

Gender: Male/Female/Others

I, Uttam Kumar Roy (Patient's name) aged 40 (herein after mentioned to as "I" or "Me"), referred by Dr. Self Pst., hereby authorize Genepowerx Personalized Medicine Clinic Private Limited (hereinafter referred to as the "Clinic") to conduct genomics tests and analysis (hereinafter referred to as "Services/Test"). I hereby agree to submit the sample for testing as recommended by my physician/medical practitioner. I understand that the samples will be collected by a qualified lab technician using medically accepted techniques, which have been explained by my medical practitioner and are acceptable to me.

By signing this declaration of consent, I acknowledge that I have read and understood all the terms stated herein below:

1. The medical practitioner/ physician has fully and clearly explained the outcomes, benefits and limitations of the whole exome sequencing. I hereby agree that I have had an opportunity to discuss and clarify the risks and other concerns with the medical practitioner. I hereby give my free consent to the Clinic to conduct the Test on the sample provided by me.
2. I shall provide accurate medical and personal information about my age, medical history, health concerns, symptoms, dietary habits, allergies, medications, lifestyle habits, family history and/or any other details /questions that enables the Clinic to conduct and interpret the results of the tests effectively. I, therefore, confirm and declare that all the information and materials provided by me are true, accurate and complete to the best of my knowledge.
3. I, shall not hold the Clinic responsible or liable for the interpretation or analysis of the tests conducted by the Clinic solely based on the medical information provided by me.
4. I understand that though genomics testing provides generally accurate results, several sources of errors are possible including but not limited to the possibility of a failure or error in sample analysis, as with the case of any genomics tests. I understand that genomics tests are relatively new and are being improved and expanded continuously. Hence, due to current limitations in technology and incomplete knowledge and information on genes and diseases, there is a possibility that the test results may be inconclusive, uninterpretable or of unknown significance which may require further testing.

5. I hereby understand that the results/outcome of the tests conducted by the Clinic is indicative and cannot be perceived as conclusive or guaranteed. I also understand that the Test reports may provide information not anticipated and unrelated to my reported clinical symptoms, but can be of medical value for patient care. I understand that the results of my tests are not be read in isolation and further clinical correlation may be required.
6. I understand that the Clinic is not a specimen banking facility and therefore the sample shall be discarded after 2(two) months and shall not be available for future clinical tests.
7. I understand that the report and any record of my personal data including but not limited to my name, age, address, symptoms, descriptions, Test reports etc. in the possession of the Clinic is in safe custody and in an encrypted form and I hereby provide my consent to the Clinic to store my personal data and information for medical research purpose.
8. I further consent and authorize to the collection, processing, use, storage and retention of the anonymized data, the sample collected and related anonymized reports from the tests conducted for ongoing test developments, educational, scientific research and/or other related activities. I understand that analytics will be done only for this study with this particular sample. I understand that the Clinic has taken the appropriate measures to maintain confidentiality. I hereby understand that this is purely for the purpose mentioned hereinbefore and my identity shall not be revealed in any manner whatsoever.
9. I further give my consent to access my test reports and electronic health reports from AIG for further investigation/analytics.
10. I understand that the clinic shall not disclose or hand-over the results of the tests to anyone else other than me, unless until required by law or expressly authorized by me.
11. I herein agree that a copy of this consent form is retained by me for any future use that may arise.



Uttam Kumar Roy

Signature of the Patient/ Guardian in case of a minor