

- BioCell Therapy
- Detox Therapy
- Immun-Vital Therapy
- Diabetes Management
- Chronic Diseases
- BioCell AntiAging
- Women & Men Power Therapy
- Acid-Base Balance

## OWC DNA Health Profile Form

### OWC Genetic Risk Profile

#### SECTION 1. PERSONAL INFORMATION

Full Name:

First Name:

Last Name:

Date of Birth:

DD/MM/YYYY

Gender:

Female

Male

Diverse

Email Address:

Phone / Mobile Number:

Address:

Street Address:

City:

Region:

Postal / Zip Code:

Country:

Ethnicity / Ancestry Background:

Reason for Testing:

Known Previous Genetic Tests:



#### HOLISTIC DIAGNOSIS AND INDIVIDUAL THERAPY

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## MEDICAL & FAMILY HISTORY

Past Medical History:

Family History: (esp. cancer, cardiac, neuro)

Current Diagnoses:

Current Medications:

Supplements / Herbs:

Allergies / Intolerances:

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## LIFESTYLE & WELLNESS

Smoking:

Never  Former  Current

Alcohol:

None  Occasional  Regular

Exercise:

Sedentary  Moderate  Active

Diet:

Standard  Mediterranean  Vegetarian  
 Keto  Other:

Sleep Quality:

Poor  Fair  Good

Stress Level:

Low  Moderate  High

## FOR FEMALES ONLY

*If you were assigned female at birth, please complete this section. If not, please skip it.*

Reproductive History: (e.g., pregnancies, miscarriages)

Menopause Status:

Premenopausal  Perimenopausal  Postmenopausal

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**EXTENDED FAMILY HEALTH PROFILE**

Please list health conditions in your immediate and extended family, including parents, grandparents, siblings, children, aunts/uncles.

Focus on serious or long-term conditions such as cancer, heart disease, diabetes, neurological or autoimmune disorders. If known, include age at diagnosis and whether the family member is still living.

**Family History Table (3 Generations)**

Relative	Health Condition(s)	Age Diagnosed	Current Age or at Death	Notes
Mother				
Father				
Sibling(s)				
Children				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Aunt / Uncle				

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## HEALTH CONDITIONS

Check if any of the following occurred in your family:

(✓ = Yes, leave blank if Unknown or No)

### Neurological / Psychiatric:

<input type="checkbox"/> Alzheimer's / Dementia	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Autism / Developmental delay	<input type="checkbox"/> Schizophrenia / Bipolar
<input type="checkbox"/> Depression / Anxiety	

### Cardiovascular:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Stroke	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Sudden Cardiac Death	

### Metabolic:

<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Type 2 Diabetes
<input type="checkbox"/> Obesity	<input type="checkbox"/> Metabolic Syndrome

### Cancer:

<input type="checkbox"/> Breast	<input type="checkbox"/> Ovarian
<input type="checkbox"/> Prostate	<input type="checkbox"/> Colon
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Other:

### Bone / Hormonal:

<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hormone Imbalance
<input type="checkbox"/> Menopause before age 40	<input type="checkbox"/> Fertility issues / miscarriages

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Autoimmune / Inflammatory:

<input type="checkbox"/> Thyroid (Hashimoto's / Graves)	<input type="checkbox"/> Lupus
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Multiple Sclerosis

Known Genetic Conditions:

<input type="checkbox"/> BRCA1/2	<input type="checkbox"/> Lynch Syndrome
<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Other:	

### RED FLAG INDICATORS

Any of the following increases the importance of DNA testing:

<input type="checkbox"/> Cancer diagnosed under age 50	<input type="checkbox"/> Multiple relatives with the same condition
<input type="checkbox"/> Sudden unexplained death in family	<input type="checkbox"/> Known genetic mutation in family
<input type="checkbox"/> Recurrent miscarriages or infertility	<input type="checkbox"/> Unusual or rare disorders

### DNA TEST CONSENT

Consent\*

I confirm that the above information is correct and I consent to the use of my data for DNA testing and clinical assessment.

Your Signature: (Patient or Guardian)

Date Signed: