PHARMA SCIENCE™
the indian ayurveda
LIC.NO. : MP25D/16/487

Dr.:_____
Add.:_____
_____
Contact No.:_____

Anti-Piles Complete Resolution
Patient Feedback Form

Date:-_____ **Treatment ID No. (According to Consent FormNo)**_____

1. **Patient's Name (First)**_____ **(Middle)** _____
   Last name:-_____
2. **S/O or W/O:-**_____
3. **Address:-**_____ **Landmark** _____
   Pin Code:-_____ **City** _____ **State** _____
4. **Patient's Phone Number** _____
5. **Alternate Phone Number (** ☐ **cell or** ☐ **office):** _____
6. **E-Mail Address:** _____
7. **Treatment Starting Date** _____
8. **Treatment End Date** _____
9. **No. of External Hemorrhoids before Treatment:** _____
10. **No. of External Hemorrhoids during the 1st Phase of Treatment:-**_____
11. **No of Removed Hemorrhoids at the End of Treatment:-**_____

Patient Review

_____
_____
_____

Patient Signature:-_____