STEM CELLS & REGENERATIVE MEDICINE

FAX CONFIDENTIALLY TO 267.935.7703

The information disclosed in this questionnaire will be kept confidential and will help STEM CELLS & REGENERATIVE MEDICINE to provide you a better service in your needs of medical assistance.

Name:

Date of birth:

ID Number:

Do you have been diagnosed in the past or currently been receiving treatment by a Doctor for any of the following conditions?

CONDITIONS	Yes	No	MEDICATIONS
AIDS/HIV			
Arthritis Reunmatica			
Another type of arthritis			
Back disease			
Scoliosis			
Spina Bifida			
Paralysis			
Multiple Sclerosis			
Cerebral Palsy			
Epilepsy			
Parkinson's disease			
Alzheimer's disease			
Liver disease			
Gastric ulcer			
Bowel disease			
Stroke			
Cancer			
Chronic bronchitis			
Asthma			
Lung disease			
Tumors			
Juvenile diabetes			
Diabetes Mellitus			
High pressure			
Hemophilia			
Heart attack			

CONDITIONS	Yes	No	MEDICATIONS
Heart disease			
Kidney disease			
Urinary problems			
Alcohol dependence			
Drug dependence			
Anorexia			
Bulimia			
Chronic depression			
Mental illness			

Transplantation of organs:

Have you ever received an organ transplant? YES ___ NO___.

If Yes, date above: _____________. Organ: ______________.

General health

1. In general, the State of my health is Good ____ Average ____ Poor ____
2. Do you use tobacco products? YES _____ NO ____ if you do, would like to quit? Yes____ No ____
3. Are you worried or stressed? Yes_____ No _____.
4. Do you do physical activities? Yes ___ No ___. If performed, how long a day? ____.
5. How tall are you? ______________. How much do you weigh? ________________.

If you are a woman:

Are you pregnant? Yes____ No____. If it is Yes, when is your due date? ____.

Additional medications:

Currently this taken prescription drugs? Yes____ No_____.
If Yes, please explain:

Condition		Medications

I, the undersigned, have completed this to the best of my knowledge.

____

Patient Signature TODAYS DATE: _________