# THE CENTER FOR REGENERATIVE ORTHOPEDICS

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## Confidential Patient Case History

Full Name:_____ Date:_____

Address:_____City:_____State:_____Zip:_____

Birthdate:_____ Age:_____ Sex:_____ Martial Status:_____

Home phone:_____ Cell phone:_____ E-mail:_____

Employer:_____ Occupation:_____ Work phone:_____

In case of emergency:_____Relationship:_____

Phone number:_____ _____

How did you find us:_____

Primary Condition you are seeking treatment for:_____

Describe all symptoms, dates of onset and any other pertinent information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

## Confidential Patient Case History

Last Name:_____ First Name:_____ MI:_____

Have you ever been hospitalized?:_____

If yes, for what?:_____

Have you ever been diagnosed with any form of cancer? _____Yes _____ No

Type:_____ Date of diagnosis:_____

Status:_____

Have you ever had a blood transfusion:_____

SURGICAL HISTORY: Check all that apply

☐ Appendectomy: Date:_____
☐ Cardiac Bypass Surgery: Date:_____
☐ Cholecystectomy: Date:_____
☐ Hernia Repair: Date:_____
☐ Liposuction: Date:_____
☐ Other surgery:_____ Date:_____

**Smoking Status**

☐ Current Smoker
☐ Former Smoker Quit Date:_____
☐ Never Smoked

**Alcohol Use**

Do you drink alcohol, beer, or wine? _____ Yes _____No
How many drinks per (fill one out): Day:_____ Week:_____

Date of last Medical Check up:_____ Where:_____

Physician:_____ Phone:_____

Results:_____

_____

## Confidential Patient Case History

Last Name:_____ First Name:_____ MI:_____

Personal Medical History: Conditions - Current or treated in the past: Check all that apply

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Benign Prostatic hyperplasia
- ☐ Bipolar Disorder
- ☐ Blood Clot
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Congestive Heart Failure
- ☐ COPD / Breathing Problems
- ☐ Coronary Artery Disease
- ☐ Cataracts
- ☐ Dementia/ Memory Loss
- ☐ Depression
- ☐ Diabetes
- ☐ Hypoclycemia
- ☐ Diverticulosis
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg / Foot Ulcers
- ☐ Liver Disease
- ☐ Obesity
- ☐ Liver Problems
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Seizures
- ☐ Stroke
- ☐ Migraines
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infections
- ☐ **NONE**

**Female History:** Is there a possibility you are pregnant: _____Yes _____ No
Have you had a breast biopsy: _____Yes _____No
Results:_____
Have you had a C-Section: _____Yes _____ No

**Male History**
Date of last PSA:_____ Result:_____

**Allergies and Adverse Drug Reactions**
Are you allergic to any antibiotic or drug? _____ Yes _____No

If yes, please list:_____

Please list all current medications:_____

_____

Nutritional Supplements / Herbal Supplements:_____

_____

## Confidential Patient Case History

Last Name:_____ First Name:_____ MI:_____

**Review of Symptoms**
Do you currently have any of the following symptoms? Please check all that appropriate boxes:

**Eyes, ears, nose, throat**

- ☐ Blurred Vision
- ☐ Other change in vision
- ☐ Loss of hearing
- ☐ Sinus problems
- ☐ Nose bleeds

**Pulmonary**

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Wheezing

**Cardiovascular**

- ☐ Chest Pain
- ☐ Irregular beat / Tachycardia
- ☐ History of poor circulation
- ☐ History of Angina or Heart Attack

**Gastrointestinal**

- ☐ Poor Appetite
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Nausea or vomiting
- ☐ Rectal Bleeding or blood in stools
- ☐ Recent weight gain or loss

**Muscle / joint / bone**

- ☐ Swelling of ankles or legs
- ☐ Weakness or numbness in:
  - ____Arms or hands
  - ____ Legs or feet
- ☐ Muscle pain
  - ____ Neck or shoulders
  - ____Back pain
- ☐ Joint pain

**Neurological**

- ☐ Blackouts or loss of consciousness
- ☐ Poor sleep
- ☐ Headaches
- ☐ Dizziness
- ☐ Loss of memory
- ☐ Speech problems

**Genitourinary**

- ☐ Frequent or painful urination
- ☐ Blood in urine
- ☐ Incontinence

**Skin**

- ☐ Itching
- ☐ Easy bruising

**Endocrine**

- ☐ Change in tolerance to hot or cold
- ☐ Excessive thirst
- ☐ Hot flashes

**Confidential Patient Case History**

Last Name:_____ First Name:_____ MI:_____

Do you have any special requirements?_____

Have you received a Stem cell treatment before? _____ Yes _____ No

Date:_____ If yes please describe:_____

What do you intend to accomplish with the treatment you are seeking?_____

_____

☐ **I understand this is a Patient Funded Treatment**

This is a patient funded treatment and cannot be covered by any insurance providers, which will require the patient to pay for the cost of the treatment. The cost will vary depending on the type of treatment, patient's condition(s) and delivery method needed.

**Disclaimer:**

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I have read and understand the disclaimer:

Initial:_____ Date:_____

**By signing and dating below, I do hereby certify that to the best of my knowledge all the above information on this form that I have supplied is complete and true.**

Print Name:_____

Signature:_____ Date:_____