The Regenerative Stem Cell Institute

650 East Devon Ave, Suite 152
Itasca, IL 60143

Confidential Patient Information

Name_____

Address _____

City, State _____

Postal Code _____

Country _____

Phone _____

Email Address _____

Ethnicity_____ Height (inches):_____ Weight (pounds):_____

Date of Birth (mm/dd/yy): _____ Age:_____ Gender: M / F

How did you hear about us?_____

Emergency Contact

Name: _____ Phone:_____

Last Name	First Name	Middle Initial

CHIEF COMPLAINT: Please describe in **ONE SENTENCE** your main problem:

_____

_____

Please check any of the following you have:

☐ Heart Failure	☐ Heart Attack	☐ Stroke	☐ High Blood Pressure
☐ COPD/Emphysema	☐ Kidney Disease	☐ Ulcer Disease	☐ Hepatitis
☐ Diabetes	☐ Artificial Joints	☐ Kidney Stones	☐ High Cholesterol
	☐ Artificial Heart Valves		

OTHER MEDICAL PROBLEMS:

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

PREVIOUS SURGERIES	DATES
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Any Family History of Genetic Problems: _____

_____

_____

Last Name	First Name	Middle Initial

MEDICATIONS YOU TAKE

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

ALLERGIES

SOCIAL HISTORY/HABITS:

Are you? Married ☐ Divorced ☐ Never married ☐

Do you have children? ☐ Yes (how many? _____) ☐ No

I am: ☐ currently working as a _____

☐ retired from work as a _____

☐ unemployed

Have you ever used tobacco? ☐ yes ☐ no If yes, how much? _____

Do you currently smoke? ☐ yes ☐ no If yes, how much? _____ (packs per day)

Do you drink alcohol? ☐ yes ☐ no How many drinks per day? _____

Have you ever had a transfusion? ☐ yes ☐ no

Have you ever used recreational intravenous drugs? ☐ yes ☐ no

Are you HIV+ or do you have AIDS? ☐ yes ☐ no

Last Name	First Name	Middle Initial

HISTORY & REVIEW OF SYSTEMS

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING? If yes, explain below:

EYES:

Decreased vision	☐ yes	☐ no
Blurred vision	☐ yes	☐ no
Double vision	☐ yes	☐ no

PULMONARY (LUNG):

Shortness of breath	☐ yes	☐ no
Chronic cough	☐ yes	☐ no
Coughing of blood	☐ yes	☐ no
Asthma	☐ yes	☐ no
Emphysema	☐ yes	☐ no
Tuberculosis	☐ yes	☐ no

GASTROINTESTINAL:

Weight loss	☐ yes	☐ no
Decreased appetite	☐ yes	☐ no
Change in bowels	☐ yes	☐ no
Blood in stool	☐ yes	☐ no
Gallbladder disease	☐ yes	☐ no
Liver/Cirrhosis	☐ yes	☐ no
Hepatitis	☐ yes	☐ no
Ulcer	☐ yes	☐ no

ENDOCRINE:

Diabetes	☐ yes	☐ no
Thyroid trouble	☐ yes	☐ no
Goiter	☐ yes	☐ no
Thyroid medication	☐ yes	☐ no

URINARY TRACT:

Kidney trouble	☐ yes	☐ no
Kidney stone	☐ yes	☐ no
Bloody urine	☐ yes	☐ no
Frequent urination	☐ yes	☐ no
Painful urination	☐ yes	☐ no
Sugar/Albumin urine	☐ yes	☐ no
Passing urine/night	☐ yes	☐ no
Slow starting/urine	☐ yes	☐ no
Weak urine stream	☐ yes	☐ no
Incontinence	☐ yes	☐ no
Prostrate disease	☐ yes	☐ no
Frequent urine infection	☐ yes	☐ no

EARS, NOSE MOUTH & THROAT:

Decreased hearing	☐ yes	☐ no
Ringing in ears	☐ yes	☐ no
Mouth pain or swelling	☐ yes	☐ no

CARDIAC (HEART):

Heart disease	☐ yes	☐ no
High blood pressure	☐ yes	☐ no
Chest pain or pressure	☐ yes	☐ no
Heart murmurs	☐ yes	☐ no
Heart palpitations	☐ yes	☐ no

MUSCULAR/SKELETAL:

Back pain	☐ yes	☐ no
Arthritis/Rheumatism	☐ yes	☐ no
Muscle pain or weakness	☐ yes	☐ no
Osteoporosis	☐ yes	☐ no

NEUROLOGIC:

Headaches	☐ yes	☐ no
Dizzy/Faint spells	☐ yes	☐ no
Nervous disorders	☐ yes	☐ no
Epilepsy/Seizures	☐ yes	☐ no
Strokes	☐ yes	☐ no

PSYCHIATRIC:

Mental illness	☐ yes	☐ no
Depression	☐ yes	☐ no
Nervous disorders	☐ yes	☐ no

REPRODUCTIVE SYSTEM:

Venereal disease	☐ yes	☐ no
HIV positive	☐ yes	☐ no
Lumps in breast	☐ yes	☐ no
Pain in breast	☐ yes	☐ no
Nipple discharge	☐ yes	☐ no
Sexual impotence	☐ yes	☐ no

ALLERGIES:

To dust	☐ yes	☐ no
To plants	☐ yes	☐ no
To animals	☐ yes	☐ no

EXPLANATION: _____