Confidential Medical History Form

Today's Date: ____/____/______

PATIENT INFORMATION

Patient's Name: ___________________________________ Date of Birth: ____/____/______

Address: ____

City: ___________________ State: __________________ Zip Code: ___________________

Home Phone Number: ______________________ Mobile Number: _____________________

Fax Number: ____________________ Email: _______________________________________

Marital Status: ____________________ Occupation: ________________________________

Referred By: ____

PARENT / GUARDIAN INFORMATION

Guardian's Name: ____

Address: ____

City: ___________________ State: __________________ Zip Code: ___________________

Home Phone Number: ______________________ Mobile Number: _____________________

Email____

EMERGENCY CONTACT INFORMATION

Name: ____________________________________ Relationship: _______________________

Home Phone Number: ______________________ Mobile Number: _____________________

TREATMENT REQUIREMENTS

Please confirm you have read and understand the requirements below to receive treatment:

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

This is a patient funded treatment and unfortunately 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.

☐ **I am able and willing to travel to receive treatment** *(please select all that apply)*

☐ I am able to travel within my state
☐ I am able to travel to surrounding states
☐ I am able to travel inside the U.S.
☐ I am able to travel outside of the U.S.

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Last Name: _______________________ **First Name:** _______________________ **M.I.** _____

PAST MEDICAL HISTORY

Primary condition you are seeking treatment for: ___________________________________

Date of diagnosis: ____/____/______

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

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CONFIDENTIAL

Confidential Medical History Form

GLORY REGENERATIVE CENTER

Last Name: ______________________ **First Name:** ______________________ **M.I.** _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check the appropriate boxes):

[__] Heart Disease

[__] High Cholesterol

[__] High blood pressure

[__] Low blood pressure

[__] Diabetes [__] Hypoglycemia

[__] Asthma

[__] Emphysema

[__] Pulmonary Fibrosis

[__] Chronic bronchitis

[__] Seasonal allergies

[__] Glaucoma

[__] Seizures [__] Stroke [__] Migraines

[__] Depression

[__] Kidney problems

[__] Liver problems

[__] Arthritis

[__] Thyroid problems

[__] Prostate problems

Have you ever been diagnosed with any form of cancer? [__] Yes [__] No

Type: ____________________________________ Date of Diagnosis: ____/____/______

Status: ____

Please describe any current or past medical condition that is not included in the list above:

____

Have you ever been hospitalized? [__] Yes [__] No

If yes, what for? ____

____

Please list all past surgeries:

Procedure: ____ Date: ____/____/______

Procedure: ____ Date: ____/____/______

Procedure: ____ Date: ____/____/______

Procedure: ____ Date: ____/____/______

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Last Name: ________________________ **First Name:** ________________________ **M.I.** _____

Have you ever received a blood transfusion? [__] Yes [__] No | Date: ____/____/______

ALLERGIES AND ADVERSE DRUG REACTIONS

Are you allergic to penicillin or any other drug? [__] Yes [__] No

If yes, please list: ____

____

____

Please list your current medications: ____

____

____

Nutritional supplements / Herbal Preparations: _____________________________________

____

____

SOCIAL AND PREVENTATIVE HISTORY

Do you currently smoke or chew tobacco? [__] Yes [__] No

If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

If No, Have you in the past? [__] Yes [__] No

If yes, how many packs per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

Do you drink alcohol, beer, or wine? [__]Yes [__] No

If yes, how many drinks per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

If No, Have you in the past? [__] Yes [__] No

If yes, how many drinks per… (fill out one) Day: _____ **or** Week: _____ **or** Month: ______

Age: _______________ **Height:** _______________ **Weight:** ___________ **Sex:** ____________

Date of your last medical check-up: ____/____/______

Physician: ______________________________________ **Telephone:** _______________________

Results of your last medical check-up: ____

____

____

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Last Name: ______________________ First Name: ______________________ M.I. _____

FAMILY HISTORY

Has any member of your family had any of the following illnesses? If yes, please place an "X" in the appropriate boxes to identify all illnesses/conditions of your blood relatives.

	Mother	**Father**	**Brother**	**Sister**	**Grandparents**	**Other**
Breast Cancer						
Colon Cancer						
Other Cancer						
Heart Disease						
High Blood Pressure						
Diabetes						
Liver Disease						
Depression						
Psychiatric Illness						
Other (Please Specify)						

Females History

Date of Last Mammogram: ____/____/______ Mammogram Results: ______________________

Have you ever had a breast biopsy? [__] Yes [__] No

Biopsy results: ____

Males History

Date of Last PSA: ____/____/______ Result: _____________________________________

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GLORY REGENERATIVE CENTER

Last Name: ______________________ **First Name:** ______________________ **M.I.** _____

REVIEW OF SYMPTOMS

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

Eyes, ears, nose, throat

- ☐ Blurred vision
- ☐ Other change in vision
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Hoarseness
- ☐ 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
- ☐ Weight gain/loss of 10+ lbs during last 6 months

Muscle / joint / bone

- ☐ Swelling of ankles or legs
- ☐ Weakness or numbness in:
  - [__] Arms or hands
  - [__] Hips
  - [__] 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 temperatures
- ☐ Excessive thirst
- ☐ Hot flashes

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Last Name: ______________________ **First Name:** ______________________ **M.I.** _____

Do you need assistance when walking? [__] Yes [__] No

Do you require a wheel chair? [__] Yes [__] No

Other requirements? ____

Have you received a stem cell treatment before? [__] Yes [__] No

Date of last treatment: ____/____/______ **If yes, please describe:** ______________________

____

____

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

____

____

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.

____ Date: ____/____/______
Patient / Legal Guardian Signature

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