Clínica Santa Clarita

novastem

**MEDICAL HISTORY QUESTIONNAIRE**

Enrollment Form

Please be sure to include details about current medications, limitation to your activities of daily living and information on any past or present physical or speech therapy. Also, it is important to mention that your records and any information about your condition or the treatments you seek or have had cannot be discussed with anyone not mentioned in this form.

## *Patient Personal Information*

Date:____________________________

Last Name __________________________________________First Name______________________

Date of Birth_______________________Age __________

Sex: ____________________Weight:___________________ Height:_________________________

Address:____________________________________________________________________________

Street

City State/Providence Zip Code/ Country

Cell Phone __________________________Home Phone__________________________(optional)

Email__________________________________Occupation_________________________________

Patient's condition or reason for seeking treatment: (briefly explain) _______________________

## *Contact Person*

Last Name __________________________________________First Name______________________

Cell Phone ____________________________________E-mail_______________________________

Relationship with patient_____________________________________________________________

Last Name __________________________________________First Name______________________

Cell Phone ____________________________________E-mail_______________________________

Relationship with patient_____________________________________________________________

Name of Primary Care Physician:_______________________________________________

Date of Last Laboratory Exam_______________ Physician's Phone #____________________

Please check the appropriate boxes:

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

If yes, what type? ____________________________When? _________________________

Status? ____________________________________________________________________

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**Harmful Habits**

| | | |
|---|---|---|
| Excessive alcohol consumption (Current) | Yes | No |
| Excessive alcohol consumption (in the past) | Yes | No |

**Cardiovascular Problems**

| | | |
|---|---|---|
| Myocardial Infarction……… | Yes | No |
| If yes, when?_______________ | | |
| Angina Pectoris……… | Yes | No |
| Tachycardia……… | Yes | No |
| By-pass Surgery……… | Yes | No |
| If yes, when?_______________ | | |
| Pacemaker?……… | Yes | No |
| Hypertension (high blood pressure)……… | Yes | No |
| Hypotension (low blood Pressure)……… | Yes | No |
| Poor Arterial Circulation……… | Yes | No |
| Poor Venous Circulation……… | Yes | No |
| Varicose Veins……… | Yes | No |
| Tingling sensation in arms and legs……… | Yes | No |
| Falling asleep of the hands and legs……… | Yes | No |
| Leg ulcers……… | | |

**Gastrointestinal Problems**

| | | |
|---|---|---|
| Stomach or duodenal ulcer……… | Yes | No |
| If yes, when?_______________ | | |
| Pancreas Problem ……… | Yes | No |
| Pancreatitis……… | Yes | No |
| Pancreatic Insufficiency ……… | Yes | No |
| Hepatitis……… | Yes | No |
| Icterus (Jaundice)……… | Yes | No |

**Pulmonary System**

| | | |
|---|---|---|
| Tuberculosis……… | Yes | No |
| Asthma……… | Yes | No |
| Chronic Bronchitis……… | Yes | No |
| Chronic Cough……… | Yes | No |
| Emphysema……… | Yes | No |

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**Neurological System**

Headaches........................................................................................................ Yes No
Sleep Disturbances........................................................................................... Yes No
Dizziness ......................................................................................................... Yes No
Chronic Migraine.............................................................................................. Yes No

**Endocrine System**

Diabetes Mellitus.............................................................................................. Yes No
Thyroid............................................................................................................. Yes No
Adrenal gland dysfunction ................................................................................ Yes No

**Rheumatism**

Rheumatic Screen.............................................................................................. Yes No
Soft Tissue Rheumatism..................................................................................... Yes No
Articular Rheumatism........................................................................................ Yes No
Joint Pain.......................................................................................................... Yes No
Back Pain.......................................................................................................... Yes No
Rheumatoid Arthritis ........................................................................................ Yes No
Other, please list ______________________________________________

**Allergy History**

Have you ever had an allergic reaction to the following:
Food, especially eggs......................................................................................... Yes No
Vaccines............................................................................................................ Yes No
Medications....................................................................................................... Yes No
Hay Fever.......................................................................................................... Yes No
Allergic Asthma................................................................................................. Yes No
Symptoms of reaction________________________________________

**General Information:**

Disabilities........................................................................................................ Yes No

Impairments...................................................................................................... Yes No

Ongoing physical therapy?
Past physical therapy?........................................................................................ Yes No
Dates
Speech therapy?................................................................................................. Yes No

Past physical therapy?........................................................................................ Yes No
Dates
Last Hospitalization

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Previous Medications (prescription and non-prescription):_______________________________

Current Medications (prescription and non-prescription)________________________________

Anti-coagulated? Yes No

Since when?______________________________Why?________________________________

Are you a diabetic? Yes No

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Describe the history of your condition:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
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Expectations and Goals (mandatory for inclusion consideration)
What are your expectations of the treatment you are seeking?

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Is there any additional information you would like to add?

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**Disclaimer:** Stem cell therapy is still undergoing clinical trials around the world. Although it has shown very promising results for many indications, each patient may respond differently to stem cell therapy, and there is no guarantee or warranty in any manner as to the results an individual patient may obtain. There have been no reported negative events in the use of Stemedica's stem cells in any clinical trial, and it has not been reported to be harmful or dangerous when used in dosages administered by this medical staff. A staff physician will review each patient's medical history and determine if that patient is a candidate for stem cell therapy.