**STEM CELL PATIENT INFORMATION**

This is a general questionnaire to assess your medical condition(s) for consideration for Stem Cell treatment. Please answer **ALL** questions fully and to the best of your knowledge. The more information you offer, the better idea Dr Beulink will have of your medical history. If you have problems answering this questionnaire, please contact Ruth on Ph (09) 5232 560 or (03) 3555 712 for advice.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mr / Mrs / Miss / Ms / Mx Male / Female / Non Binary Age: \_\_\_\_\_\_\_\_\_

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL CONTACT ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBERS:

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If retired, what was your primary occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have medical insurance? If so, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary medical condition(s) for which you are considering stem cell treatment? Please give a precise and detailed description of your diagnosis to the best of your knowledge.

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Please give details of your current condition to the best of your knowledge.

(eg: Have you had any tests or X-rays confirming your diagnosis? How long have you suffered this? How does this affect you? What parts of you does this affect? What is the current level of severity? What past treatments/surgery have you had for this?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What doctors are you seeing for this condition? Eg, have you seen a specialist? What type of specialist? What prognosis (outlook/what do they say) have you been given for your condition?

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GENERAL HEALTH

What is your height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

Do you carry fat around your abdomen/tummy (enough to grab with your fingers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a smoker? \_\_\_\_\_\_\_How many cigs. per day\_\_\_\_\_\_\_\_ For how many years?

If you are an ex-smoker, how many cigs. per day were you?\_\_\_\_\_For how many years?

When did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please state your current alcohol intake. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current level of mobility?

a) I can easily climb 2 flights of stairs without a break

b) I can climb 2 flights of stairs with a rest break.

c) I can walk unencumbered on a flat surface only

d) I can walk on a flat surface with help

e) I cannot walk

Do you have: HIV? \_\_\_\_\_\_ Hep A B or C? \_\_\_\_\_\_

Please state any other medical condition(s) you are currently suffering from, including approximate date of onset.

Please give a brief outline of any past and present medical conditions, or surgery including dates.

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Please list all current medications you are taking, including reasons why, and dosage of each medication.

Please list all natural remedies you are currently taking, including reasons why, and dosage of each. eg; colostrum, antioxidants etc.

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Please list any allergies you have, including medications, and state what reaction you have to each substance.

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Have you or any family had blood or bleeding complaints, disorders or problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a surface or deep vein clot/blood clot in your leg, leg eczema, leg ulcers or a very swollen leg? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family ever had a vein clot / blood clot in the leg? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Finally, where were you referred from, or where did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you.