Welcome to Regenerative Medicine Clinic OF WILMINGTON

Today's Date: _____

Patient Information

Name: _____
First Last MI Preferred Name

❑ Male ❑ Female Date of Birth: _____ Age: _____ SS#: _____

Phone # (Mobile)_____ (H) _____ (W) _____

Email: _____

Preferred method of communication: ❑ Phone ❑ Email

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Next of kin (spouse):_____ Phone: _____ Relation: _____

How did you hear about our practice? _____
❑ Star News ❑ State Port Pilot ❑ Internet

Health Insurance Information

Primary Insurance Company Name: _____

Policy Holder (if different from patient) Name: _____ SS# _____ DOB: _____

Primary Insurance ID#: _____ Group Plan # _____

Secondary Insurance Company Name: _____

Policy Holder (if different from patient) Name: _____ SS# _____ DOB: _____

Secondary Insurance ID#: _____ Group Plan # _____

Primary Care Physician_____

Are you currently being treated by other medical professionals? □Yes □No

If yes please list name and what you are being treated for:_____

_____

Office use only

BP: _____ Pulse: _____ O2 Saturation: _____ MAP: _____

BMI: _____ BMI Percentile: _____

Health Information

Height:_____ **Weight:**_____

Why are you seeing us today? _____

❑Right ❑Left ❑Both

How long have you had symptoms? _____ Days _____ Months _____ Years

Symptoms: ❑ Come & go ❑Are constant

❑Rapidly improving ❑ Slowly improving ❑ Gradually worsening
❑ Fluctuating ❑ Remains the same ❑ Rapidly worsening

What does it feel like? ❑ Sharp ❑ dull ❑ aching ❑ throbbing

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Please indicate treatments (other than surgery) you have tried for the condition:

❑ Bracing ❑ Prescription Drugs (please specify)_____

❑ Exercise Program ❑ Over-the-Counter Drugs (please specify)_____

❑ Physical Therapy ❑ Hyaluronic Acid Injections (date of last injection/ how many) _____

❑ Steroid Injections (date of last injection/ how many) _____

What makes it better? _____

What makes it worse? _____

What do you want to be able to do that you can't? _____

How has this problem affected your daily activities:_____

Your exercise habits: ❑ Never ❑ Daily ❑ Weekly ❑ Occasionally

Type of exercise: ❑ Walk ❑ Run ❑ Bike ❑ Swim ❑ Weight Train ❑ Other _____

Participate in sports? ❑ Yes ❑ No If yes, what sports? _____

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following?
Alcohol _____drinks/week Cigarettes _____packs/day Former Smoker_____

Have you ever been treated for any of the following medical conditions? Please check yes or no and **circle** all that apply. Explain further in the space provided if necessary.

□**Yes** □**No** Arthritis (rheumatoid, osteo-degenerative) _____
□**Yes** □**No** Blood Diseases (anemia, leukemia, clotting problems) _____
□**Yes** □**No** Ear, Nose, Throat (hearing loss, sinus disease) _____
□**Yes** □**No** Diabetes (type, how controlled & when diagnosed) _____
□**Yes** □**No** Thyroid Disease (hypo, hyper, Graves disease) _____
□**Yes** □**No** Lung Disease (asthma, emphysema, COPD, chronic bronchitis) _____
□**Yes** □**No** Heart Disease (heart attack, arrhythmia, heart failure, heart valve disease)_____
□**Yes** □**No** High Blood Pressure _____
□**Yes** □**No** Gastrointestinal Disease (ulcers, esophageal reflux, intestinal or liver disease) _____
□**Yes** □**No** Genito-Urinary Disease (kidney disease, dialysis, kidney stones) _____
□**Yes** □**No** Neurological Problems (stroke, mini strokes, seizures, paralysis)_____
□**Yes** □**No** Skin Diseases (eczema, psoriasis, acne rosacea) _____
□**Yes** □**No** Mental Health (depression, anxiety, schizophrenic, bipolar) _____
□**Yes** □**No** Cancer (list type or location & date) _____
□**Yes** □**No** Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) _____
Other Problems _____
Previous Surgery (date/reason)_____
_____

Do you have night sweats? □**Yes** □**No**

Have you had any recent weight loss? □**Yes** □**No**

Have you had any chest or heart surgery? □**Yes** □**No**
If yes, please explain_____

Is there a family history of any of the following conditions (please indicate which relative)?
❑ Heart Disease _____ ❑ Diabetes _____ ❑ Lung Disease _____
❑Cancer _____ ❑ Arthritis _____ ❑ Other _____

List All Medications

Include over-the-counter/ Vitamins/ Herbal Supplements

Name	Dosage	How many/ How often

Allergies and Reactions:

❑ No Known Drug Allergies

Medication	Reaction