

For office use only

Regenecell Patient Folder No. _____

Patient Evaluation Form – Heart Disease

Click or use the TAB key to move between fields

Full Name

Date of Birth

Occupation

Gender Male Female

Physical Address

Country

Postal Address

Zip/Postal Code

Tel No.

Cellphone

Email

Re-enter email

Skype user name

Your Personal Doctor

Name

Telephone

Fax

Email

Contact in an emergency while at the clinic (caregiver, close friend or relative)

Name

Tel no.

Medical history:

Disease for which you are seeking treatment

Date of first diagnosis

Other Diagnoses

Date

What events lead up to you being diagnosed with this disease?

History of events after diagnosis

How would you describe your current condition?

Your Height

Your Weight

Have you experienced sudden weight loss (above 5kg)? Yes No

Do you have, or have you suffered from:

	Yes	No	If Yes, please elaborate
Allergies: food, vaccination, drugs, hayfever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems – nervousness, depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis type: A	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis type: B	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis type: C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Renal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes type 1	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes type 2	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overactive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Underactive	<input type="checkbox"/>	<input type="checkbox"/>	_____

Menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Are you on?</u>			
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	_____
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medication

Name	Dose	Strength	Date Started	Date Stopped

Smoking

Amount per day

When started

When stopped

CARDIAC FAILURE AND ISCHEMIC HEART DISEASE

Type Left heart failure Right heart failure

Cause

- Ischemic heart disease/Myocardial infarction (coronary artery disease)
- Thyrotoxicosis (hyperthyroidism)
- Anemia
- Arrhythmia
- Hypertension
- Coarctation of the aorta
- Valve disease – specify

Symptoms

	Yes	No	If Yes, please elaborate
Shortness of breath on exercise	<input type="checkbox"/>	<input type="checkbox"/>	_____
orthopnoea (shortness of breath lying down)	<input type="checkbox"/>	<input type="checkbox"/>	_____
paroxysmal nocturnal dyspnoea	<input type="checkbox"/>	<input type="checkbox"/>	_____
fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
haemoptysis (coughing up blood)	<input type="checkbox"/>	<input type="checkbox"/>	_____
wheeze/tight chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
palpitations	<input type="checkbox"/>	<input type="checkbox"/>	_____
ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
night-time waking with shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
frequent night-time urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
weight loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath on exercise	<input type="checkbox"/>	<input type="checkbox"/>	_____
orthopnoea (shortness of breath lying down)	<input type="checkbox"/>	<input type="checkbox"/>	_____
paroxysmal nocturnal dyspnoea	<input type="checkbox"/>	<input type="checkbox"/>	_____

The following information will be available from your cardiologist:

Ejection fraction: % Date of test:

New York Heart Association Classification

Tick one

- Class I No symptoms and no limitation in ordinary physical activity.
Class II Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
Class III Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
Class IV Severe limitations. Experiences symptoms even while at rest.

How did you hear about Regenecell?

- Internet Search
- Personal referral By whom: _____
- Other Details: _____

I understand that Regenecell Stem Cell Therapy is not a US FDA-approved procedure and is in no way to be construed or presented as a cure for any condition, degenerative disease or injury, and clinical benefits from this therapy cannot be guaranteed.

I accept the above

Return this form as an attachment to info@regenecell.com

Or

By Fax: + 27 86 503 2563

From the UK: 00 27 86 503 2563
From the USA: 011 27 86 503 2563