

For office use only

Regenecell Patient Folder No. _____

Patient Evaluation Form – Multiple Sclerosis

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

Multiple Sclerosis

Weakness

	None	Mild	Moderate	Severe
Right upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Left lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nerve impairment

	Yes	No	If Yes, please elaborate
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have any of the following symptoms?

	Yes	No	If Yes, please elaborate
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Memory impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of fine hand movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abnormal or decreased sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spasticity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____

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