

For office use only

Regenecell Patient Folder No. \_\_\_\_\_

## Patient Evaluation Form – Rheumatoid Arthritis

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	<input type="text"/>
When started	<input type="text"/>
When stopped	<input type="text"/>





**Rheumatoid Arthritis**

Do you have any of the following symptoms?

	Yes	No	If Yes, please elaborate
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Malaise	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oedema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stiffness worse in the morning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stiffness persists for more than 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
No of joints affected			_____
Which joints and side			_____
Finger deformities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid nodules	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vasculitis	<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](mailto: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