

For office use only

Regenecell Patient Folder No. _____

Patient Evaluation Form - Stroke

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"/>	_____

Do you have any of the following symptoms?

Sensory Loss	Left Side	Right Side
Upper limbs	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>
Thorax	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
Face below eyes	<input type="checkbox"/>	<input type="checkbox"/>
Face above eyes	<input type="checkbox"/>	<input type="checkbox"/>
Motor Loss	Left Side	Right Side
Upper limbs	<input type="checkbox"/>	<input type="checkbox"/>
Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>
Face below eyes	<input type="checkbox"/>	<input type="checkbox"/>
Face above eyes	<input type="checkbox"/>	<input type="checkbox"/>
Eye movement affected	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	If Yes, please elaborate
Difficulty putting words in correct order or context:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty articulating words	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty finding the correct word	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to speak	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to identify common objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Additional speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Mild	Moderate	Severe
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gait impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Incontinence

	Yes	No
Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Bladder	<input type="checkbox"/>	<input type="checkbox"/>

Smell

	Yes	No
Sense of loss of smell	<input type="checkbox"/>	<input type="checkbox"/>

Vision

	Left Eye		Right Eye	
Visual Field Loss	Central	Peripheral	Central	Peripheral
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Mild	Moderate	Severe
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Seizures
Please describe

Medication

Name	Dose	Strength	Date Started	Date Stopped
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Smoking

Amount per day

When started

When stopped

Alcohol

Type	Amount per day/week
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Family history of disease:

Disease	Mother	Father	Grandmother	Grandfather	Brother	Sister
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Supplementation

List all nutritional supplements – please include brand names.

Stroke

Please send a detailed medical report from your cardiologist and neurologist.

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