CellMed Regenerative Medicine
12840 Hillcrest Plaza Drive
Suite E104
Dallas, TX 75230
214-442-8908

Pre-Procedure Evaluation

Patient Name: _____ Arrival Time: _____ am/pm

Sex: _____ Birthdate: _____ Age: _____ Weight: _____

SS#: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Referring Physician: _____

Follow Up Appointment Scheduled: Yes/No Date: _____ Time: _____

Health Insurance Company: _____

Person Insured: _____ Relationship: _____

Insured's Birthdate: _____ Insured's Social Security #: _____

Policy #: _____ Group #: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

X_____ (please initial) I authorize this facility to release any information or films which we were acquired in the course of my examination or treatment. Written reports generated from your visit will be provided to your referring physician. You may obtain a copy of the written report from your referring physician.

X_____ (please initial) I understand that this office bills insurance as a courtesy and that the payment of these services are my responsibility. I permit the insurance company to make payment directly to CellMed Regenerative Medicine for services rendered. Also to appeal any claims to my insurance on my behalf. This does not apply to TWCC guidelines.

Signature: _____ Date: _____

For office use only:

Name: _____

Date Received: _____

Proc. Site(s): _____

AUTOLOGOUS CELLULAR BLOOD GRAFT (ACBG) PRE-PROCEDURE AND MEDICAL QUESTIONNAIRE

(PLEASE PRINT & COMPLETE QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE USING BLACK INK)

Patient Demographics

Name: _____, _____, _____
Last First Middle

Home Address: _____ City: _____ State: _____

Zip: _____ Occupation: _____ Employer: _____

Employer Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

DOB: _____ Last 4 Digits of SSN: _____ Gender: Male ☐ Female ☐ Height: _____ Weight: _____

Blood Type: _____ Resting Blood Pressure: _____ Average Glucose Level: _____

Marital Status: _____ Spouse's Name: _____

Name of your Pharmacy: _____ Phone #: _____

Emergency Contact Information:

Name:	Relationship:	Phone:
_____	_____	_____
_____	_____	_____

Medical Problems (past & present) & date (approx.) when first occurred:

Condition:	Date:	Condition:	Date:
1_____	_____	5_____	_____
2_____	_____	6_____	_____
3_____	_____	7_____	_____
4_____	_____	8_____	_____

Have you been under the care of a specialist? Yes ☐ No ☐

If so, please provide name(s) of physician(s):

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Patient Demographics

Have you had a prior surgery/surgeries of any kind? Yes ☐ No ☐
If yes, please indicate the date and type of surgery:

Date: ____/____/_____ Type of Surgery: _____

Date: ____/____/_____ Type of Surgery: _____

Date: ____/____/_____ Type of Surgery: _____

Date: ____/____/_____ Type of Surgery: _____

Date: ____/____/_____ Type of Surgery: _____

Has any medical doctor recently recommended you have any surgical procedure? Yes ☐ No ☐
If yes, please list surgery/surgeries recommended:

Date Recommended: ____/____/_____ Type of Surgery: _____

Date Recommended: ____/____/_____ Type of Surgery: _____

Date Recommended: ____/____/_____ Type of Surgery: _____

Are you allergic to latex, tape adhesive, or other items? Yes ☐ No ☐ If yes, please explain: _____

Diet

Are you a vegetarian? Yes ☐ No ☐
If yes, please list your source of protein and the frequency of intake below:

Source: _____ Frequency: _____

Source: _____ Frequency: _____

Source: _____ Frequency: _____

Are you allergic to beef products, such as milk, cheese, etc.? Yes ☐ No ☐
How many times per month do you eat red meat? _____/ month
How many times per month do you eat fish? _____/ month
Does your diet include a regular intake of fruits and vegetables? Yes ☐ No ☐

Medical History

Have you ever been diagnosed with any type of cancer? Yes ☐ No ☐
Remission Date: _____ Comments: _____

If you are seeking ACBG wound care, is the wound associated with any type of cancer? Yes ☐ No ☐
Remission Date: _____ Comments: _____

Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney disease) or seizures?
Yes ☐ No ☐ If yes, please explain: _____

Do you have low blood or platelet counts? Yes ☐ No ☐

Are you taking blood thinners or anticoagulants? Yes ☐ No ☐

Have you been diagnosed with arthritis? Yes ☐ No ☐ If yes, what type? _____

Are you allergic to Heparin, blood anticoagulants, ACD-A, etc.? Yes ☐ No ☐

Do you have any type of active infection(s)? Yes ☐ No ☐
If so, what type and where? _____

Are you currently taking or have you taken any prescribed medications during the past 6 months? Yes ☐ No ☐
If yes, please list all prescribed medications you are currently taking: _____
_____
Please list all prescribed medications you are currently off of, but you have taken during the last 6 months (please indicate date of last dose):

Medication: _____ Date: ____/____/_____

Medication: _____ Date: ____/____/_____

Medication: _____ Date: ____/____/_____

Medication: _____ Date: ____/____/_____

Are you currently taking or have you taken any over-the-counter medications during the past 6 months?

Yes ☐ No ☐ If yes, please list all over-the-counter medications you are currently taking:
_____
Please list all over-the-counter medications you are currently off of, but you have taken during the last 6 months (please indicate date of last dose):
_____
_____

Do you take over-the-counter pain relievers? Yes ☐ No ☐
If so, please list which ones, frequency and dosage: _____

Are you allergic to any medications? Yes ☐ No ☐
If so, please list: _____

Do you have any vitamin or mineral deficiencies? Yes ☐ No ☐
If so, please list: _____

Do you take vitamin and/or nutritional supplements? Yes ☐ No ☐
If so, please list vitamin and/or nutritional supplements you take and dosage: _____
_____

Do you take steroids? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ If yes, what form and how frequently? _____

Do you use tobacco products? Yes ☐ No ☐ If yes, what form and how frequently? _____

Are your vaccinations/immunizations up to date? Yes ☐ No ☐

Do you take antibiotics routinely before dental check-ups or surgery? Yes ☐ No ☐

For Female Patients:

Date of last menstrual period: ____/____/_____ Post-menopausal? Yes ☐ No ☐

Are you pregnant, trying to become pregnant, or experiencing a late menstrual period? Yes ☐ No ☐

Are you taking oral contraceptives or receiving hormonal treatment? Yes ☐ No ☐

Are you taking any fertility medicine or having fertility treatments? Yes ☐ No ☐
If yes, describe: _____

Are you currently breastfeeding? Yes ☐ No ☐

Have you ever been diagnosed with any of the following diseases:

	Yes	No		Yes	No
Appendicitis …….	☐	☐	Chicken Pox …….	☐	☐
Scarlet Fever……..	☐	☐	Type I Diabetes …….	☐	☐
Diptheria ……	☐	☐	Type II Diabetes ……..	☐	☐
Typhoid Fever……	☐	☐	Heart Disease……..	☐	☐
Pneumonia ……..……	☐	☐	Goiter……..……	☐	☐
Rheumatic Fever ……..	☐	☐	Influenza……..……	☐	☐
Polio ……..……	☐	☐	Cancer……	☐	☐
Malaria ……..……	☐	☐	Alcoholism ……..	☐	☐
Tuberculosis ……	☐	☐	Arthritis ……..	☐	☐
Whooping Cough ……..	☐	☐	Venereal Disease ……..	☐	☐
Anemia ……..	☐	☐	Epilepsy ……..	☐	☐
Measles ……..	☐	☐	Mental Disorder ……..	☐	☐
Mumps ……..	☐	☐	Eczema ……..	☐	☐
Small Pox ……..	☐	☐	Pleurisy ……..	☐	☐
Neurological Disease ……..	☐	☐	GI Disease ……..	☐	☐

Have you experienced, do you have or have you been previously diagnosed with, treated for or received any of the following:

	Yes	No		Yes	No
Neck (Cervical Spine) Pain ……	☐	☐	Poor Appetite ……..	☐	☐
Low Back (Lumbar Spine) Pain …….	☐	☐	Excessive Appetite ……	☐	☐
Pain Between Shoulders ……	☐	☐	Excessive Thirst ……	☐	☐
Pain in Upper/Lower Extremities (Arms/Legs)	☐	☐	Insomnia/Lack of Sleep …..	☐	☐
Cold/Tingling Extremities ……..	☐	☐	Allergies ……	☐	☐
Muscle or Joint Pain/Stiffness ……..	☐	☐	Headaches ……..	☐	☐
Numbness ……..	☐	☐	Convulsions ……	☐	☐
Paralysis ……..……	☐	☐	Depression ……..	☐	☐
Recent Fever ……..	☐	☐	Confusion ……..	☐	☐
Recent Significant Weight Loss ……..	☐	☐	Chronic Fatigue ……	☐	☐
Reaction to giving or receiving blood …….	☐	☐	X-Ray or Radiation Treatments …	☐	☐
Heart Disease ……..	☐	☐	PUVA or UVB ……..	☐	☐
High Blood Pressure ……..	☐	☐	Type I Diabetes ……..	☐	☐
Hypertension ……..	☐	☐	Type II Diabetes ……..	☐	☐
Angina/Chest Pain or Shortness of Breath…..	☐	☐	Glaucoma ……..	☐	☐
Heart Attack or Congestive Heart Failure…..	☐	☐	Hepatitis or Yellow Jaundice …	☐	☐

	Yes	No		Yes	No
Heart Rhythm Disturbance ……	☐	☐	Genital Herpes ……	☐	☐
Heart Bypass Surgery ……	☐	☐	Problems Healing ……	☐	☐
Pacemaker or other implants …..	☐	☐	Excessive Scarring ……..	☐	☐
Implanted Cardioverter Defibrillator …….	☐	☐	Liver Disease ……	☐	☐
Neurostimulation system …….	☐	☐	Kidney or Bladder Disease …	☐	☐
Spinal Cord Stimulator ……	☐	☐	Prostate Dysfunction …….	☐	☐
Internal Electrodes or Wires ……..	☐	☐	Urinary Discomfort / Painful Urination	☐	☐
Bone Growth/Bone Fusion Stimulator …	☐	☐	Frequent Urination …….	☐	☐
Stroke/TIA/Carotid Artery Disease …	☐	☐	Discolored Urine ……	☐	☐
Convulsions, Seizures …….	☐	☐	Blood in Urine ……	☐	☐
Dizziness ……	☐	☐	Hemastospermia ……..	☐	☐
Fainting ……..	☐	☐	Intestinal Colitis or Crohn's Disease	☐	☐
Epilepsy ……..	☐	☐	Other Stomach/Bowel Disease …	☐	☐
Bronchitis or Emphysema ……	☐	☐	Abdominal Pain ……	☐	☐
Hay Fever or Asthma ……..	☐	☐	Diarrhea ……	☐	☐
Other Breathing Difficulty ……..	☐	☐	Constipation ……..	☐	☐
Chronic or Morning Cough …….	☐	☐	Hemorrhoids ……	☐	☐
Bleeding Disorder …….	☐	☐	Black/Bloody Stool ……..	☐	☐
Cold Sores or Fever Blisters …..	☐	☐	Thyroid Disease ……..	☐	☐
Heart Murmur ……	☐	☐	Rheumatoid Arthritis …….	☐	☐
Mitral Valve Prolapse ……	☐	☐	Lupus Erythematosus ……	☐	☐
Artificial Joint ……..	☐	☐	Scleroderma ……	☐	☐
Phlebitis (inflammation of veins) …	☐	☐	Other Collagen-Vascular Disease …	☐	☐
Varicose Veins ……..	☐	☐	Vision Defects ……	☐	☐
Blood Clots (ESP, DVT, deep vein or lungs) …	☐	☐	Hearing Defects ……	☐	☐
Peripheral Vascular Disease ...	☐	☐	Nasal Symptoms/Sore Throat …	☐	☐
Ankle Swelling ……..	☐	☐	Claustrophobia ……..	☐	☐
Bleeding Disorder ……..	☐	☐			
Blood Transfusions ……	☐	☐			
IV or Recreational Drug Use …	☐	☐			
AIDS or HIV ……..	☐	☐			

Physical Activity

How many times per week do you exercise/participate in athletics? _____
Please list the forms of exercise/athletics you participate in:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

When you exercise or participate in sport activity, do you experience pain or discomfort? Yes ☐ No ☐

If yes, please be specific and list the parts of your body where you feel pain or discomfort:

1) _____
2) _____
3) _____

Do you experience swelling/inflammation in any part of your body when you exercise or participate in athletics?

Yes ☐ No ☐

Please list the parts of your body that swelling and inflammation occurs:

_____

_____

Reason(s) for seeking Autologous Cellular Blood Graft Procedure

Describe the main reason(s) for seeking the ACBG Injection procedure. Please specify all areas of your body that you experience symptoms. Please be specific in describing injuries, wounds and conditions. How long have you been afflicted with, or experienced symptoms?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Which of the following, best describes the onset of this problem? Gradual Onset ☐ Sudden Onset ☐

Describe how your pain is trending? Improving Pain ☐ Worsening Pain ☐

Please rate your average level of pain on the scale below (circle the appropriate rating):

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Severe Pain)

Does your pain radiate to any other part of your body? Yes ☐ No☐

If yes, where? _____

What makes your pain worse? _____

What alleviates your pain? _____

Do you take Nonsteroidal anti-inflammatory drugs (NSAIDs)? *These are drugs with analgesic and antipyretic (fever-reducing) effects and which have, in higher doses, anti-inflammatory effects*: Yes ☐ No☐

If yes, frequency and dosage: _____

Past and Current Treatments

What past and/or current treatments have you undergone or are you undergoing to alleviate pain? Who is/was the provider of treatment? Where are they located?

_____

_____

_____

_____

_____

Prior Imaging/Radiology/Tests

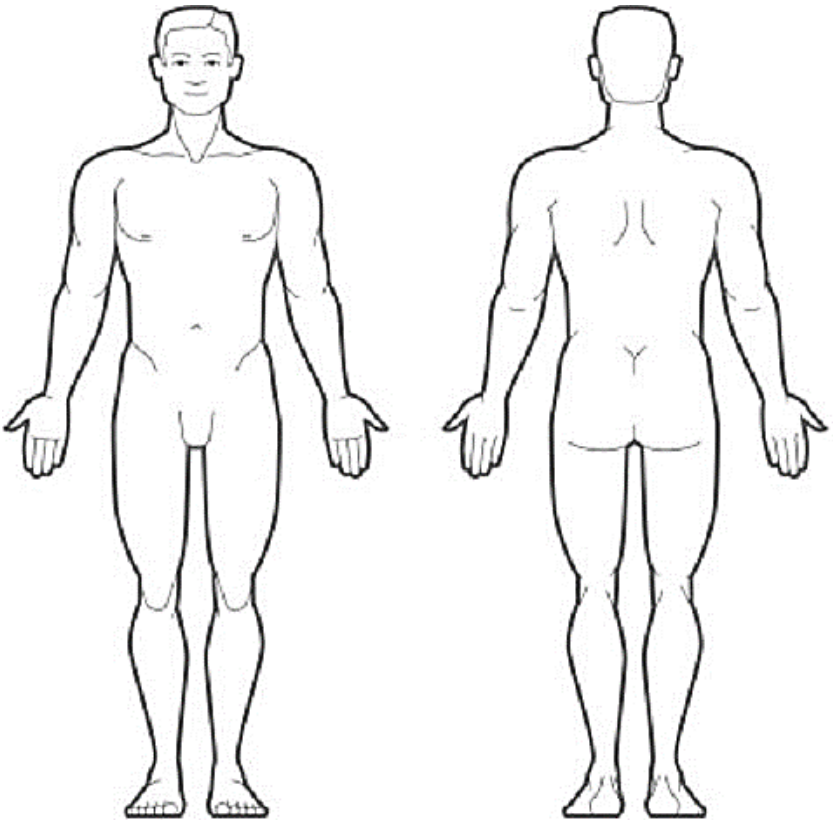
Have you had any of the following exams recently related to your chief complaint?

MRI	Yes ☐	No☐	If yes, when and what body part scanned: _____
X-Ray	Yes ☐	No☐	If yes, when and what body part scanned: _____
CT Scan	Yes ☐	No☐	If yes, when and what body part scanned: _____
EMG (Nerve Test)	Yes ☐	No☐	If yes, when and what body part scanned: _____

On the diagram below, please indicate the areas of your body that you are experiencing symptoms (pain and discomfort). You are welcome to make notations on the sides and draw arrows to affected sites.

Anterior View (Front) **Posterior View (Back)**

Right **Left** **Left** **Right**



How did you hear about this procedure?

_____

_____

_____

I attest that the above information is correct and accurate. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form.

Patient Name (Print): _____

Patient Signature: _____ Date: _____