PREMIER REGENERATIVE
Stem Cell and Wellness Centers

HISTORY AND PHYSICAL (Please complete carefully and completely) **TODAY'S DATE** _____

NAME _____ AGE _____ BIRTH DATE_____
HEIGHT _____ WEIGHT _____lbs

REVIEW OF SYMPTOMS (Mark any of these symptoms you may have had within the past year)

GENERAL: ☐ Poor appetite ☐ weight change
HEAD: ☐ Headaches
EYES: ☐ Blurred vision ☐ Double vision
THROAT: ☐ Chronic sore throats ☐ Difficulty swallowing
LUNGS: ☐ Shortness of breath ☐ Chronic cough
MOUTH: ☐ Loose teeth ☐ False teeth ☐ Dental problems
HEART: ☐ Chest pain ☐ Heart pounding ☐ Swollen ankles ☐ Swollen hands
ABDOMEN: ☐ Nausea ☐ Vomiting ☐ Change in bowel habits ☐ Blood in stool ☐ Recurrent indigestion ☐ Abdominal pain
GU: ☐ Frequent urination ☐ Pain or burning with urination

****HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? ☐ YES ☐ NO**

PAST MEDICAL HISTORY: (Mark if you have ever had any of the following)

☐ Anemia	☐ Epilepsy/Seizures	☐ Lung Disease/COPD	☐ Diabetes Adult/Child
☐ Anxiety/Depression	☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Insulin Dependent
☐ Arthritis	☐ Hard of Hearing	☐ Nervous Breakdown	☐ Emphysema
☐ Blood Clots in Legs/Lungs	☐ Heart Disease/Heart Attack	☐ Pneumonia	☐ Jaundice
☐ Bowel Disease	☐ Hernia-Hiatal/Other	☐ Polio	☐ Kidney Disease
☐ Breast Cysts or Lumps	☐ Hepatitis	☐ Poor Vision	☐ Liver Disease
☐ Bleeding Disorder	☐ High Blood Pressure	☐ Rheumatic Fever	☐ Tuberculosis
☐ Cancer	☐ High Cholesterol/Triglycerides	☐ Skin Disease	☐ Ulcers
☐ Chronic Bronchitis	☐ HIV	☐ Thyroid Problem	☐ MRSA
☐ Dizziness	☐ Sleep Apnea	Other _____	

CARDIAC HISTORY
Have you ever been treated for a heart problem? ☐ YES ☐ NO
Name and Number of Cardiologist _____ Last visit/EKG _____

FAMILY HISTORY	**Maternal**	**Paternal**
Blood Disease	☐	☐
Heart Attack/Disease	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Tuberculosis	☐	☐
Problems with Anesthesia	☐	☐
Lung Disease	☐	☐
Birth Defects	☐	☐
Liver Disease	☐	☐
Kidney Disease	☐	☐

SOCIAL HISTORY

Do you smoke cigarettes?	☐ YES ☐ NO
Packs/Day	_____
Have you ever smoked cigarettes?	☐ YES ☐ NO
When did you stop?	_____
Do you chew tobacco?	☐ YES ☐ NO
Do you use "street" drugs?	☐ YES ☐ NO
Do you drink alcohol daily?	☐ YES ☐ NO
Have you ever taken Cortisone?	☐ YES ☐ NO
Any problems with Anesthesia?	☐ YES ☐ NO
Are you ☐ **LEFT** or ☐ **RIGHT** handed?	
History of drug or alcohol abuse?	☐ YES ☐ NO
Do you use medical marijuana?	☐ YES ☐ NO

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN OVER THE PAST YEAR.
Name/Strength/Frequency

_____
_____
_____
_____

LIST ALL KNOWN ALLERGIES/REACTION

_____
_____
_____
_____
_____

LIST ALL MAJOR OPERATIONS, INJURIES, OR CRONIC ILLNESSES

DATE	TYPE OF OPERATION, INJURY OR ILLNESS
_____	_____
_____	_____
_____	_____