BOTHELL REGENERATIVE MEDICINE

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PHONE NUMBER: _____ **EMAIL:** _____

ADDRESS: _____

SSN: _____

CHIEF COMPLAINT (Reason for visit): _____

_____

_____

GOALS OF TREATMENT: _____

_____

MEDICATIONS & SUPPLEMENTS (Please list name, dosage and frequency – use back if more room needed):

_____ _____

_____ _____

_____ _____

ALLERGIES: _____

SURGICAL HISTORY (Procedure and Date):

_____

_____

_____

PAST MEDICAL HISTORY (Circle all that apply):

Heart Disease	Kidney Disease	Glaucoma
Hypertension/ High Blood Pressure	Hypo/Hyperthyroidism	Depression
Hypotension/ Low Blood Pressure	Hepatitis	Anxiety
Hyperlipidemia	Ulcers	Migraines
Seizures	Arthritis/ Degenerative Joint Disease	Pancreatitis
Stroke	Anemia	Liver Disease
Diabetes	Tuberculosis	Back/ Joint Pain
Cancer (what kind?)	HIV	
Asthma/ COPD		

BOTHELL REGENERATIVE MEDICINE

FAMILY HISTORY:

	Status	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Migraine	Prostate Cancer	Pancreatitis	Multiple Endocrine Neoplasia 2 (MEN2)	Medullary Thyroid Cancer
Father											
Mother											
Brother/ Sister											
Son/ Daughter											

SOCIAL HISTORY:

Alcohol Use (Please circle): Social History of/ current alcoholism Never Light Daily

Tobacco Use (Please circle): Current user Former user Never

- Packs per day? _____ How many years? _____ Type: _____

Drug Use (Please circle): None Previous use Currently Using What/ How much? _____

Work History (Please circle): Employed Unemployed Disabled Retired

Marital Status (Please circle): Married Widowed Single Divorced/ Separated

JOINT/ MUSCULOSKELETAL PAIN QUESTIONNAIRE (Ignore if no musculoskeletal complaint):

Where is the pain located? _____

On a scale of 0 to 10, what would you rate the pain? _____

Describe the character of your pain – dull/achy, burning, shooting, stabbing/ sharp, cramping, spasming, throbbing, squeezing, tightness _____

Do you have any numbness or tingling? _____

Does the pain radiate? If so, where to? _____

When did the pain begin? _____

Is the pain constant or intermittent? Is it predictable? _____

Is there a time of day that your pain is better or worse? _____

Does anything make the pain better? _____

Does anything make the pain worse? _____

What treatments have you tried? _____

BOTHELL REGENERATIVE MEDICINE

REVIEW OF SYSTEMS (Circle all that apply):

CONSTITUTIONAL:

- Chills
- Fever
- Fatigue
- Unintentional Weight Loss or Gain

HEENT:

- Hearing Loss
- Sinus Pressure
- Visual Changes
- Headaches
- Ear Pain
- Ear Discharge
- Tinnitus

RESPIRATORY:

- Cough
- Asthma
- Hemoptysis
- Shortness of Breath
- Wheezing
- Sputum

CARDIOVASCULAR:

- Chest Pain
- Edema
- Palpitations
- Shortness of Breath While Laying Down
- Heart Murmur
- Hypertension
- DVT/PE

GASTROINTESTINAL:

- Abdominal Pain
- Bloody Stool
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting

GENITOURINARY:

- Painful Urination
- Excessive Urination
- Frequency
- Blood in Urine
- Flank Pain
- Incontinence

MALE/ FEMALE REPRODUCTIVE:

- Hernia
- Testicular Masses
- Sexual Dysfunction
- Menstruation Status: _____

MUSCULOSKELETAL:

- Back Pain
- Muscle Pain
- Neck Pain
- Joint Pain
- Joint Swelling
- Recent Trauma or Injury

INTEGUMENTARY:

- Hives
- Rashes
- Itching

NEUROLOGICAL:

- Dizziness
- Numbness or Tingling
- Extremity Weakness
- Migraines
- Seizures
- Tremors
- Loss of Sensation

PSYCHIATRIC:

- Anxiety
- Depression
- Hallucinations

METABOLIC/ ENDOCRINE:

- Cold Intolerance
- Heat Intolerance
- Excessive Hunger or Thirst
- Hair Thinning
- Dry Nails

HEMATOLOGIC/ IMMUNOLOGIC:

- Easy Bruising
- Blood Clots
- Food allergies
- Seasonal allergies

BOTHELL
REGENERATIVE
MEDICINE