BHI THERAPEUTIC SCIENCES JAMAICA

PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

DATE: **ID #:**

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:** / /	**Age:**
Address:		
Email:	**Phone:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other:		
Social Security Number:		
How did you hear about BHI Therapeutic Sciences?		

EMERGENCY CONTACT

Name *(Last, First, M.I.):*	**Phone:**
Address:	
Relationship:	

EMPLOYMENT

Employer Name:	**Phone Number:**
Employer Address:	

SOCIAL HISTORY

☐ Smoking Packs Daily? ____ How Long? _____ Interested in stopping? ☐ Y ☐ N If you quit, when did you quit? _____ How long did you smoke? _____	☐ Coffee: Cups Daily_____ Other Caffeine: _____ ☐ Alcohol: Type _____ Frequency _____ Amount _____ ☐ Diet: Salt intake _____ Fat intake _____	Sleep: Snoring ☐ Y ☐ N Daytime Drowsiness ☐ Y ☐ N Difficulty Falling Asleep ☐ Y ☐ N Continuity Disturbances ☐ Y ☐ N Early Morning Awakening ☐ Y ☐ N Other_____

Do you exercise routinely? ☐ Y ☐ N What do you do for exercise?_____
Have you ever used illegal drugs? ☐ Y ☐ N If so, what drugs?_____

MEDICAL HISTORY

Have you ever been diagnosed with any type of cancer? ☐ Yes ☐ No
If yes, please list what type:
Check box if you have ever had any of the following:

☐ Asthma ☐ Angina/Chest Pain ☐ Anemia ☐ Arthritis ☐ Glaucoma ☐ Cancer ☐ Chronic Bronchitis ☐ Cirrhosis ☐ Clotting Disorder ☐ Diabetes ☐ Emphysema ☐ Epilepsy	☐ Fractures ☐ Gallstones ☐ Heart Attack ☐ Heart Murmur ☐ Headaches ☐ Hepatitis ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV positive/AIDS ☐ Kidney Disease ☐ Kidney Stones ☐ Migraines	☐ Positive TB Test ☐ Rheumatic Fever ☐ Stroke ☐ Thrombophlebitis ☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers ☐ Other – Please List Below _____ _____ _____ _____

SURGICAL HISTORY

Date	Reason	Hospital

Is there a history of injury in the past that left you with any compromise of function?
☐ Y ☐ N Patient, if yes, please explain:

FAMILY HISTORY

Family Member Name	Health Status	Arthritis	Cancer	Diabetes	Heart Condition	Lung Disease	Mental Illness	Stroke	Other	Cause of Death	Age of Death
Father											
Mother											
Siblings											
Grandparents											
Children											
Spouse											

CURRENT MEDICATIONS & DOSAGE

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Medication	Dosage	Frequency Taken

Are you currently taking any human growth hormones? ☐ Yes ☐ No

If yes, how long?	Number of IU's of HGH injected per week?

ALLERGIES	
Are you allergic to any foods, especially eggs? ☐ Yes ☐ No	Please list:
Are you allergic to any vaccinations? ☐ Yes ☐ No	Please list:
Are you allergic to any medications? ☐ Yes ☐ No	

Name of medication	**Reaction You Had**

REVIEW OF SYMPTOMS

Check box if you have any of the following symptoms:

Respiratory
- ☐ shortness of breath
- ☐ congestion
- ☐ cough
- ☐ short of breath on exertion

Endocrine
- ☐ cold intolerance
- ☐ heat intolerance
- ☐ increased thirst

Gastroenterology
- ☐ nausea
- ☐ heartburn
- ☐ constipation
- ☐ diarrhea
- ☐ difficulty swallowing
- ☐ indigestion
- ☐ abdominal pain

Urology
- ☐ frequent urination
- ☐ difficult or painful urination
- ☐ blood in urine

Dermatology
- ☐ rash
- ☐ flushing
- ☐ wound
- ☐ dry skin

Cardiology
- ☐ chest pain
- ☐ palpitations
- ☐ varicose veins
- ☐ sweating
- ☐ swelling
- ☐ fluttering sensation

Female Reproductive
- ☐ pregnant
- ☐ menopause

Male Reproductive
- ☐ difficulty with erection

Hematology
- ☐ easy bruising
- ☐ bleeding

Psychology
- ☐ depression
- ☐ anxiety
- ☐ high stress

General
- ☐ weight gain
- ☐ weight loss
- ☐ loss of appetite
- ☐ fevers
- ☐ weakness
- ☐ fatigue

Ophthalmology
- ☐ diminished vision
- ☐ blurring of vision
- ☐ loss of vision
- ☐ vision floaters

Neurology
- ☐ headaches
- ☐ tingling
- ☐ fainting
- ☐ dizziness
- ☐ difficulty walking
- ☐ memory loss

Musculoskeletal
- ☐ joint pain
- ☐ leg cramps
- ☐ back pain
- ☐ arm pain
- ☐ neck pain
- ☐ leg pain
- ☐ muscle pain

PRIMARY DIAGNOSIS/DISEASE

Reason for stem cell therapy:

☐ ALS	☐ Alzheimer's Disease	☐ Anti-aging
☐ Arthritis	☐ Autoimmune Disorder	☐ Back Pain
☐ Brain Trauma	☐ Cardiovascular Disease	☐ Cerebral Palsy
☐ CVA (stroke)	☐ Diabetes Mellitus	☐ Hypoxia
☐ Infertility	☐ Macular Degeneration	☐ Mood Disorder
☐ Multiple Sclerosis	☐ Platelet Rich Plasma (PRP)	☐ Renal Disease
☐ Sexual Dysfunction	☐ Sickle-cell Disease	☐ Spinal Cord Injury
☐ Stem Cell Facelift	☐ Thalassemia	☐ Other:

Brief Description of symptoms:

PHYSICIAN		
Name: *(Last, First,)*	**Phone:**	
Address:		
Date of your last medical checkup:		
Have you ever had stem cell treatments before? ☐ Yes ☐ No		
If yes, Location of treatment:		Date of Procedure: / /
Efficacy (ameliorate) after treatment:		
Any adverse effects after treatment? ☐ Yes ☐ No	Please specify:	
What do you intend to accomplish with the treatment you are seeking?		

Patient Signature _____

Date _____