Genesis Stemcell Technologies

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Full Name:	
DOB:	
Profession/Occupation:	
Address:	
Phone:	
Cell Phone:	
E-Mail:	
Marital status:	
Children:	
Height:	
Weight:	
Main reasons for referral :	
Source of information about our clinic	

Please, answer the questions below:	Reply "Yes" or "No" to each of the questions below	Please, specify (dates, diseases, examinations, treatment)
1. Do you have health problems at present?	Yes ☐ No ☐	
2. Have you ever lost your working capacity for more than 4 weeks over the last 5 years?	Yes ☐ No ☐	
3. Hospitalizations and surgeries in the past	Yes ☐ No ☐	
4. ***Have you had any of the diseases listed below in the past or lately?***		
Respiratory system (asthma ☐ , chronic bronchitis ☐, pneumonia ☐, tuberculosis ☐ etc..)		
Cardiovascular system (hypertension ☐, angina pectoris ☐, myocardial infarction ☐, cardiac malformations ☐, cardiac failure ☐, thrombosis ☐, arterial diseases ☐, other ☐)		
Mental and neurological diseases (loss of consciousness ☐, epilepsy ☐, paralyses ☐, neuritis ☐, head injury ☐, attempted suicide ☐, other ☐)		
Digestive system (gastritis ☐, peptic ulcer ☐, liver diseases ☐, gall bladder diseases ☐, pancreatic diseases ☐, other ☐)		
Genitourinary system (urolithiasis ☐, cystitis ☐, pyelonephritis ☐, prostatitis ☐, adnexitis ☐, other ☐)		
Skin problems (psoriasis ☐, dermatitis ☐, tumors ☐, other ☐)		
Musculoskeletal system (diseases affecting bones ☐, joints ☐, spinal cord ☐, muscles ☐, ligaments ☐, tendons ☐; rheumatism ☐, injury		

☐)		
Eyes (glaucoma ☐, cataract ☐, retinal diseases ☐, other ☐)		
Ears (Otitis (ear infection) ☐, hearing loss ☐, other ☐)		
Endocrine or blood diseases (diabetes mellitus ☐, gout ☐, thyroid diseases ☐, adrenal diseases ☐, anemia ☐, coagulation failure ☐, other ☐)		
Immune system disorders or infectious diseases (HIV/AIDS ☐, viral hepatitis (B,C, E, F) ☐, other ☐)		
Other diseases not specified above	Yes ☐ No ☐	
Tumors	Yes ☐ No ☐	
Hernia (any type)	Yes ☐ No ☐	
Rheumatism	Yes ☐ No ☐	
Stroke, CVA (cardiovascular accident)	Yes ☐ No ☐	
Organ transplantation	Yes ☐ No ☐	
Tuberculosis	Yes ☐ No ☐	
5. Have you ever been tested for HIV?	Yes ☐ No ☐	
6. Are you taking any medications including painkillers, sleeping pills, tranquilizers?	Yes ☐ No ☐	
7. Are you on drugs (narcotic substances)?	Yes ☐ No ☐	
8. Do you have allergies?	Yes ☐ No ☐	
9. Have you ever been treated for sexually transmitted diseases (STDs) over the last year? Have you ever had venereal diseases?	Yes ☐ No ☐	

Do you presently experience the symptoms listed below?	Reply "Yes" or "No" to each of the statements below	Please, specify (dates, diseases, examinations, treatment)
1. Weight loss/gain	Yes ☐ No ☐	
2. Appetite changes	Yes ☐ No ☐	
3 Fever, shivering	Yes ☐ No ☐	
4. Urination problems	Yes ☐ No ☐	
5. Dizziness	Yes ☐ No ☐	
6. Eyesight problems	Yes ☐ No ☐	

7. Loss of consciousness	Yes ☐ No ☐	
8. Pain or discomfort in the abdomen	Yes ☐ No ☐	
9. Digestion problems, heartburn, gas	Yes ☐ No ☐	
10. Diarrhea or loose stool	Yes ☐ No ☐	
11. Constipation	Yes ☐ No ☐	
12. Sleep disorder	Yes ☐ No ☐	
13. Mood alterations, stress, depression, anxiety, fears	Yes ☐ No ☐	
14. Family or work problems causing stress	Yes ☐ No ☐	
15. Sexual problems	Yes ☐ No ☐	
16. Hearing problems/ ear diseases	Yes ☐ No ☐	
17. Swallowing problems/ throat diseases	Yes ☐ No ☐	
18. Cough	Yes ☐ No ☐	
19. Blood in saliva/ sputum	Yes ☐ No ☐	
20. Breathing problems	Yes ☐ No ☐	
21. Chest pain ☐, pressure ☐, or discomfort ☐		
22. Pulse/cardiac rhythm disturbance	Yes ☐ No ☐	
23. Edema ☐ or joint pain ☐		
24. Skin diseases	Yes ☐ No ☐	
25. Headache	Yes ☐ No ☐	
26. Backache	Yes ☐ No ☐	
27. Weakness, fatigue	Yes ☐ No ☐	
28. Do you get bruises easily?	Yes ☐ No ☐	
29. Gait problems	Yes ☐ No ☐	
30. Breast pain ☐, hypersensitivity ☐, induration ☐		
31. Pain and tumors in pelvis	Yes ☐ No ☐	
32. Nausea ☐, vomiting ☐		
33. Pain and discomfort at urination	Yes ☐ No ☐	

For women only

1. Is your menstrual cycle regular?	Yes ☐ No ☐
2. Do you have children?	Yes ☐ No ☐
3. Premenstrual syndrome (lower abdominal pain, back pain, headache)	Yes ☐ No ☐
4. Abortions ☐, diagnostic curettage ☐, Caesarean section ☐	
5. Have you ever had urinary incontinence?	Yes ☐ No ☐
6. Genitourinary infections within the last year	Yes ☐ No ☐
Date of the latest gynecological examination	

For men only

1. Do you feel that your urinary bladder is not totally empty after urination?	Yes ☐ No ☐
2. Do you feel a need to pass urine earlier than 2 hours after the last urination?	Yes ☐ No ☐
3. Have you noticed that your urine stream has become weak?	Yes ☐ No ☐
4. How often do you need to strain in order to pass the urine?	
5.? Do you wake up at night to pass the urine?	Yes ☐ No ☐
6. Do you have children?	Yes ☐ No ☐
7. Genitourinary infections over the last year	Yes ☐ No ☐
Date of the latest urology examination	

Lifestyle

Physical load	Reply "Yes" or "No" to each of the statements below.
Inactive (sedentary) lifestyle (hardly any exercise)	Yes ☐ No ☐
Minimal physical activity (going upstairs, walking up to 3 bocks, golf)	Yes ☐ No ☐
Irregular physical activity (physical work or exercising (active rest) max 4 times a week for 30 min.)	Yes ☐ No ☐
Regular physical activity (physical work or exercising (active rest) 4 times a week for 30 min.)	Yes ☐ No ☐
Other	
Please, describe your usual day	
Nutrition	
Your dietary habits	
Are you on a diet?	Yes ☐ No ☐
If yes, was the diet recommended by the doctor?	
Alcohol	
How often do you drink alcohol and in what amounts?	
Are you concerned about the amount of alcohol you drink?	Yes ☐ No ☐
Do you have drinking bouts?	Yes ☐ No ☐
Smoking	
Do you smoke?	Yes ☐ No ☐
If, yes, how many cigarettes do you smoke per day?	
Have you tried to give up smoking?	Yes ☐ No ☐

Mental health

	Reply "Yes" or "No" to each of the questions below.
Is stress a big problem for you?	Yes ☐ No ☐
Do you panic when you are stressed?	Yes ☐ No ☐
Do you feel depressed?	Yes ☐ No ☐
Has your appetite changed?	Yes ☐ No ☐
How often do you cry?	Yes ☐ No ☐
Have you ever tried to commit suicide?	Yes ☐ No ☐
Have you ever consulted psychotherapist for any reason?	Yes ☐ No ☐

Treatment in the past and its results	
Present medications (names, doses, regimen)	
Doctors' plans regarding further treatment	