

# Beyond Stem Cells

1-833-720-STEM (7836)

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status (circle): Married Divorced Single Widow

Spouse / Partner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Please Describe your Symptoms and reason for appointment: \_\_\_\_\_

\_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Are you suffering from the following (circle):

FATIGUE

DEPRESSION

DECREASE IN MEMORY

MOOD SWINGS

DECREASE IN ENERGY LEVEL

HEADACHES/MIGRAINES

DECREASE IN SEXUAL DESIRE

DECREASE IN MUSCLE MASS

ANXIETY

UNCLEAR THINKING

IRRITABILITY

WEIGHT GAIN

SLEEP PROBLEMS

Do you smoke? \_\_\_\_\_ If so, how much? \_\_\_\_\_ Number of years? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ If so What? \_\_\_\_\_

Do you drink Alcohol? \_\_\_\_\_ How many drinks on average per week? \_\_\_\_\_

Have you ever used any form of Testosterone or Hormone Therapy? \_\_\_\_\_

How many hours of sleep do you get on an average night? \_\_\_\_\_

Previous Treatments: \_\_\_\_\_

\_\_\_\_\_

Please circle any of the following that you ever have had or been treated for:

DIABETES	HYPERTENSION	HEART DISEASE	STROKE	HEART MURMUR
KIDNEY DESEASE	RHEUMATIC FEVER	MITRAL VALVE	HEPATITIS	LIVER DISEASE
PHLEBITIS	THYROID DYSFUCTION	BLOOD TRANSFUS	ASTHMA	VARICOSE VEINS
EMPHYSEMA	CHRONIC BRONCHITIS	LEUKEMIA	ALLERGIES	GI ISSUES
COLON POLYPS	PSYCHIATRIC DISORDERS	MULTI MYELOMA	CANCER	ANEMIA
ARTHRITIS	LUPUS	SCLERODERMA	OSTEOPOROSIS	OSTEOPENIA

Please describe any of the above or add any other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please list any drug allergies: \_\_\_\_\_

Please list all current medications: \_\_\_\_\_

\_\_\_\_\_

Please list all hospitalizations and surgeries: \_\_\_\_\_

Name and number of primary Physician: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_