REGENERATIVE MEDICINE LA

Dr. Mark M. Ghalili, DO
Director of Regenerative Medicine

Name:	DOB: Age:
Address: *City, State, Zip*	
Mobile Phone: Home Phone:	Email:
☐ Male ☐ Female	Marital status: ☐ Single ☐ Partnered ☐ Married Separated ☐ Divorced Widowed
Occupation:	**How were you referred?**
Emergency Contact Name & Number:	
Medical Insurance Provider? PPO or HMO?	Subscriber ID: Social Security Number:

What has prompted you to schedule a consultation?

Health Concerns & Past Medical History	Date started	Diagnosis given	Treatments received

HEALTH GOALS

Please state your health goals:

Have you ever been prescribed Cipro, Levaquin, Avelox or any Fluoroquinolone antibiotic, if so what year and how long was the duration of treatment?

If you were prescribed Cipro or Levaquin, were you prescribed **ibuprofen, steroids, antidepressants, or antifungals, or antacid medication,** with or after consuming the antibiotic, please clarify?

Review of Systems: Circle those that apply:
General: Overall health [Excellent / Good / Fair/ Poor] Fevers / Chills / Night Sweats Fatigue / Rash / Itching
Skin: Moles / Hair loss / Nail changes / Dryness / Ulcers / Color changes
Head/Eyes/Ears/Nose/Throat: Headaches /Decreased hearing / Ringing / Sinus pain Congestion / Dental problems / Oral ulcers / Sore throat / Decreased hearing Sinus pain Congestion /Hoarseness / Trouble swallowing
RESPIRATORY: Cough / Sputum / Shortness of breath [at rest / upon exertion]
CARDIOVASCULAR: Chest pain / Edema (swelling) / Palpitations
GASTROINTESTINAL: Poor appetite / Heartburn / Vomiting / Abdominal pain / Constipation Hemorrhoids / Nausea / Bloating / Diarrhea
GENITOURINARY: Urgency / Hesitation / Frequency / Painful urination / Incontinence / Blood in urine
GYNECOLOGICAL: Pelvic pain / Breast tenderness / Vaginal bleeding / Discharge / Mass
MUSCULOSKELETAL: Tendon pain / Muscle weakness / Muscle fatigue / Muscle aches / Back pain Neck pain / Achilles pain / Arm weakness / Shoulder pain / Knee pain / Hip pain
HEMATOLOGIC: Easy bleeding / Bruising / Blood clots / Anemia
NEUROLOGIC: Headaches / Neuropathy / Muscle twitches / Vertigo / Balance issues Brain fog / Numbness
PSYCHIATRIC: Psychosis / Suicidal thoughts / Panic attacks / Hallucinations / Hopelessness

MEDICATIONS AND SUPPLEMENTS (if more room needed, write on separate page)

Medication/Supplement	Prescribed Dosage (e.g.mg amount)	Frequency Taken

Are you on any special diet?

Recreational Drug use? What drug?

Do you smoke cigarettes? For how many years? Smoke: cigars or pipe For how many years?

Do you drink alcohol? If yes, what type and how often?

Past Surgical History:

Allergies:

Tell me about your Family Medical History?

Do you have a family history of any medical conditions including autoimmune disease, HIV, or Hepatitis C? Clarify

Are you interested in learning more about Stem Cell Treatment? ☐ Yes ☐No

The above information is accurate and complete to the best of my knowledge:

Patient Signature: _____ Date: _____