RBI
REGENERATIVE BIOLOGICS
& AGE MANAGEMENT INSTITUTE

CONFIDENTIAL MEDICAL HISTORY

TODAY'S DATE: _______ /_______ /_______

PATIENT INFORMATION:

Patient Name: ____________________ Date of Birth: _______ /_______ /_______

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Home Phone Number: (_______) ________ - ____________ Cellular Number: (_______) ________ - ____________

Email: ____________________ Fax Number: (_______) ________ - ____________

Marital Status: ____________ Referred By (how did you hear about RBI?: ____________________

Regular Physician: ____________________

PARENT / GUARDIAN INFORMATION:

Guardian's Name: ____________________

Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Home Phone Number: (_______) ________ - ____________ Cellular Number: (_______) ________ - ____________

Reason for contacting RBI:

____

____

____

Describe all symptoms, dates of onset and any other pertinent information:

____

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PERSONAL MEDICAL HISTORY: Conditions or treated in the past. (Check all that apply)

- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Benign Prostatic Hyperplasia
- ❑ Bipolar Disorder
- ❑ Blood Clot
- ❑ Cancer (Add comments below)

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- ❑ Chronic Bronchitis
- ❑ Congestive Heart Failure
- ❑ COPD / Breathing Problems
- ❑ Coronary Artery Disease
- ❑ Cataracts
- ❑ Dementia / Memory Loss
- ❑ Depression
- ❑ Diabetes ❑ Hypoglycemia
- ❑ Diverticulosis
- ❑ Eating Disorder
- ❑ Emphysema
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Heartburn / Gastric Reflux
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Leg / Foot Ulcers
- ❑ Liver Disease
- ❑ Liver Problems
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Seizures ❑ Stroke ❑ Migraines
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Urinary Tract Infections
- ❑ None

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Have you ever been diagnosed with any form of cancer? ❑ Yes ❑ No

Type: ______________________ Date of Diagnosis: _______/_______/__________

Status: ______________________

Please describe any current or past medical condition that is not included in the list on previous page:

____

____

____

SURGICAL HISTORY: (Check all that apply)

❑ Appendectomy	Date: _______/_______/_______	**COMMENTS:**______________________
❑ Cardiac Bypass Surgery	Date: _______/_______/_______	______________________
❑ Cholecystectomy	Date: _______/_______/_______	______________________
❑ Hernia Repair	Date: _______/_______/_______	______________________
❑ Other Abdominal Surgery	Date: _______/_______/_______	______________________
❑ Liposuction	Date: _______/_______/_______	______________________
❑ None		

SMOKING STATUS: ❑ Current Smoker ❑ Former Smoker

ALCOHOL USE: Do you drink alcohol, beer, or wine? ❑ Yes ❑ No

If yes, how many drinks per (fill out one) **Day** _______ or **Week** _______

FAMILY HISTORY: (Please list any relevant family history)

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____

____

MEDICATIONS and NUTRITIONAL SUPPLEMENTS: (Please list)

____

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____

❑ None

ALLERGIES: (Please list)

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❑ None