# Appointment Checklist :

- If you have any recent X-rays and/or MRI'S (within the last 6 months), please bring them with you to the consultation.

- Expect to be in the office for up to 2 hours

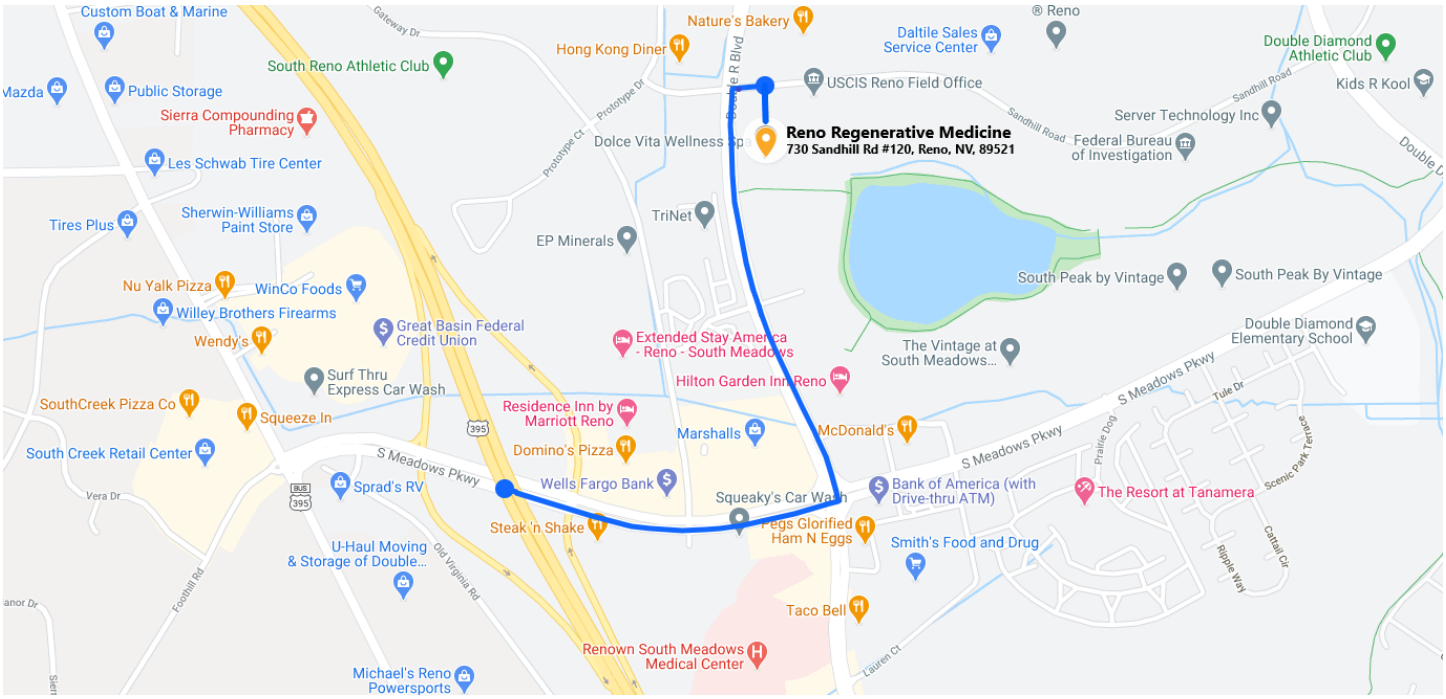
- Make sure you have your photo ID and Insurance card(s) upon arrival to the office.

- Please have your paperwork filled out prior to arriving for your consultation.

- Please understand we have set this time out for you with our Medical Provider & Case Manager, and we ask that you arrive on time for your appointment.

- Please make sure you write down and bring any questions with you to the consultation!

## Thank You!




**From North Reno:**

- Take I-580 S/US-395 S towards Carson City
- Continue to Exit 28 to S Meadows Pkwy
- Turn left on to S Meadows Pkwy & stay in the left lane
- Turn left on to Double R Blvd. Stay in the right lane
- In about half a mile, turn right on to Sandhill Rd
- Take your next right into our complex parking lot (you should turn in front of the US Citizenship and Immigration Building)
- Once you enter the complex, there will be two brown buildings to your right. We are in the farthest building “730.” Park on the East side of the building and enter in the large doors. We are on the bottom level, second door on the left.

**From South Reno:**

- Take I-580 S/US-395 North
- Take Exit 28 for S Meadows Pkwy. Turn right on to S Meadows Pkwy & merge to the left lane
- Turn left on to Double R Blvd. Stay in the right lane
- In about half a mile, turn right on to Sandhill Rd
- Take your next right into our complex parking lot (you should turn in front of the US Citizenship and Immigration Building)
- Once you enter the complex, there will be two brown buildings to your right. We are in the farthest building “730.” Park on the East side of the building and enter in the large doors. We are on the bottom level, second door on the left.

Reno Regenerative Medicine

730 Sandhill Road, Suite 120
RENO, NV. 89521

Patient Name_____ Date: _____ Email: _____

SS #/SIN_____ DOB_____ Home phone_____ Cell Phone _____ Carrier: _____

Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Male ☐Female

Patient's Address _____ City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Emergency Contact: Name_____ Relation_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Signature Date

**Responsible Party**

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? ☐ Yes ☐ No

Reno Regenerative Medicine

730 Sandhill Road, Suite 120
RENO, NV. 89521

**Do you have any Medical insurance?** ☐ Yes ☐ No If yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____

Address of Employer_____ City _____ State _____ Zip_____

Insurance Company_____ Group #_____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

# Health History

Patient Name:_____DOB:_____Date:_____

**Chief Complaint:** _____

## History of Present illness:

**Location:** _____ **Quality:** _____

(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc..)

**Severity:**_____ **Duration:** _____

(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?) (How long have you had this pain/ problem? When did it start?)

**Timing**: _____ **Context:** _____

(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

**Associated Signs/Symptoms**_____**Modifying Factors** _____

_____ _____

(What other associated problems have you been having?) (What makes the pain/problem worse or better? Have you had previous episodes?)

## Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Measles | YES \| NO | Stroke | YES \| NO | Whooping Cough | YES \| NO | Blood / Plasma Transfusion | YES \| NO |
| Mumps | YES \| NO | Anemia | YES \| NO | Bladder Infection | YES \| NO | Date of Last Chest X-Ray: | _____ |
| Chicken Pox | YES \| NO | Back Trouble | YES \| NO | High Blood Pressure | YES \| NO | Hepatitis | YES \| NO |
| Ulcer | YES \| NO | Epilepsy | YES \| NO | Low Blood Pressure | YES \| NO | Mitral Valve Prolepses | YES \| NO |
| Scarlet Fever | YES \| NO | Hepatitis | YES \| NO | Hemorrhoids | YES \| NO | Kidney Disease | YES \| NO |
| Diphtheria | YES \| NO | Tuberculosis | YES \| NO | Hives of Eczema | YES \| NO | Thyroid Disease | YES \| NO |
| Small Pox | YES \| NO | Diabetes | YES \| NO | AIDS & HIV | YES \| NO | Any Other Disease | YES \| NO |
| Rheumatic Fever | YES \| NO | Cancer | YES \| NO | Infections Mono | YES \| NO | (Please List): | YES \| NO |
| Pneumonia | YES \| NO | Polio | YES \| NO | Asthma | YES \| NO | _____ | |
| Arthritis | YES \| NO | Hernia | YES \| NO | Bronchitis | YES \| NO | _____ | |
| Venereal Disease | YES \| NO | Glaucoma | YES \| NO | Migraine Headaches | YES \| NO | _____ | |

| **Previous Hospitalizations/Surgeries/Serious Illnesses** | When? | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medication:** (include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes O no if yes what type: _____

## Patient Social History:

Marital Status Single:_____ Married:_____ Separated: _____ Divorced: _____ Widowed: _____

Use of Alcohol Never:_____ Rarely:_____ Moderate:_____ Daily:_____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type / Frequency: _____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

**MEDICAL PROVIDER SIGNATURE:**_____**DATE REVIEWED:**_____

**PATIENT NAME:**_____**DATE:**_____

Name:_____ DOB_____ Date:_____

**Family Medical History:**

| | Age | Disease | If Deceased, Cause Of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

**Eyes/Ears/Nose/Throat/Respiratory**

| | |
|---|---|
| Asthma | 1 2 3 4 5 |
| Stuffy Nose | 1 2 3 4 5 |
| Hay Fever | 1 2 3 4 5 |
| Sore throat | 1 2 3 4 5 |
| Chronic Cough | 1 2 3 4 5 |
| Chest Congestion | 1 2 3 4 5 |
| Frequent Sneezing | 1 2 3 4 5 |
| Itchy/Watery Eyes | 1 2 3 4 5 |
| Drainage | 1 2 3 4 5 |
| Earache or Ear Infection | 1 2 3 4 5 |
| Itching | 1 2 3 4 5 |
| Hoarseness | 1 2 3 4 5 |
| Shortness of Breath | 1 2 3 4 5 |

**Muscular/Skeletal**

| | |
|---|---|
| Muscle Aches | 1 2 3 4 5 |
| Fibromyalgia | 1 2 3 4 5 |
| Arthritis | 1 2 3 4 5 |
| Joint Pain | 1 2 3 4 5 |
| Low Back Pain | 1 2 3 4 5 |
| Neck Pain | 1 2 3 4 5 |
| Wrist/Hand Pain | 1 2 3 4 5 |
| Elbow Pain | 1 2 3 4 5 |
| Shoulder Pain | 1 2 3 4 5 |
| Hip Pain | 1 2 3 4 5 |
| Knee Pain | 1 2 3 4 5 |
| Ankle/Foot Pain | 1 2 3 4 5 |
| Pain between Shoulder Blades | 1 2 3 4 5 |

**General**

| | |
|---|---|
| Fatigue | 1 2 3 4 5 |
| Malaise | 1 2 3 4 5 |
| Weakness, tiredness | 1 2 3 4 5 |
| Lightheadedness | 1 2 3 4 5 |
| Irritability | 1 2 3 4 5 |
| Constipation | 1 2 3 4 5 |
| Diarrhea | 1 2 3 4 5 |
| Feeling foggy | 1 2 3 4 5 |
| Forgetfulness | 1 2 3 4 5 |

**Neurological**

| | |
|---|---|
| Headaches | 1 2 3 4 5 |
| Migranes | 1 2 3 4 5 |
| Numbness | 1 2 3 4 5 |
| Dizziness | 1 2 3 4 5 |
| Pins/Needles in Hands/Feet | 1 2 3 4 5 |
| Tingling | 1 2 3 4 5 |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Medical Provider's Review

_____ _____

Signature of Medical Provider Date

Reno Regenerative Medicine

Medication List

***If you already have a list with you, please let us make a copy and refrain from filling out this form**

| Medication Name | Dosage | Frequency |
| --- | --- | --- |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medication Allergies:_____

_____