PRE-STEM CELL TREATMENT MEDICAL EVALUATION

Patient Name _____ DOB _____

Surgical Procedure _____

Procedure Date _____ Surgeon _____

Type of Anesthesia _____

HISTORY

Medical Conditions	
Surgical History	
Medication Allergies/Sensitivity	
Medications and Doses	

PHYSICAL

Blood Pressure		Weight	
Pulse		Height	
Oxygen Saturation		Measurements	
Heart	Normal _____	Abnormal _____	
Lungs	Normal _____	Abnormal _____	
Pregnancy Test	Negative _____	Positive _____	Lot hCG #
Other Findings			

LABORATORY

Blood work	
EKG	
Comments	

_____ _____

Physician Signature Date