PATIENT FORM

Regenerativ Medicina

Dear Patient,

Please complete the interactive form carefully by clicking the light blue fields, and selecting the relevant checkboxes. The information given will assist us to gather important information of your medical history, and it will allow us to spend more time on the physical examination and discussion. It will also help us provide a thorough assessment and formulate a diagnosis so we can provide the best possible care to you.
We appreciate you taking the time to complete this form.

Kind regards,

Dr Ágnes Stogicza, Dr Edit Rácz, Dr Balázs Bartos

Personal information

Patient name:

Date of birth:

Email: Phone:

Emergency contact name:

Emergency contact phone no:

I consent to receive emails in regards to my treatment: Yes No

General information

Height: Weight:

How did you hear about us?

Name of referring doctor:

Phone: Email:

Name of your GP:

Phone: Email:

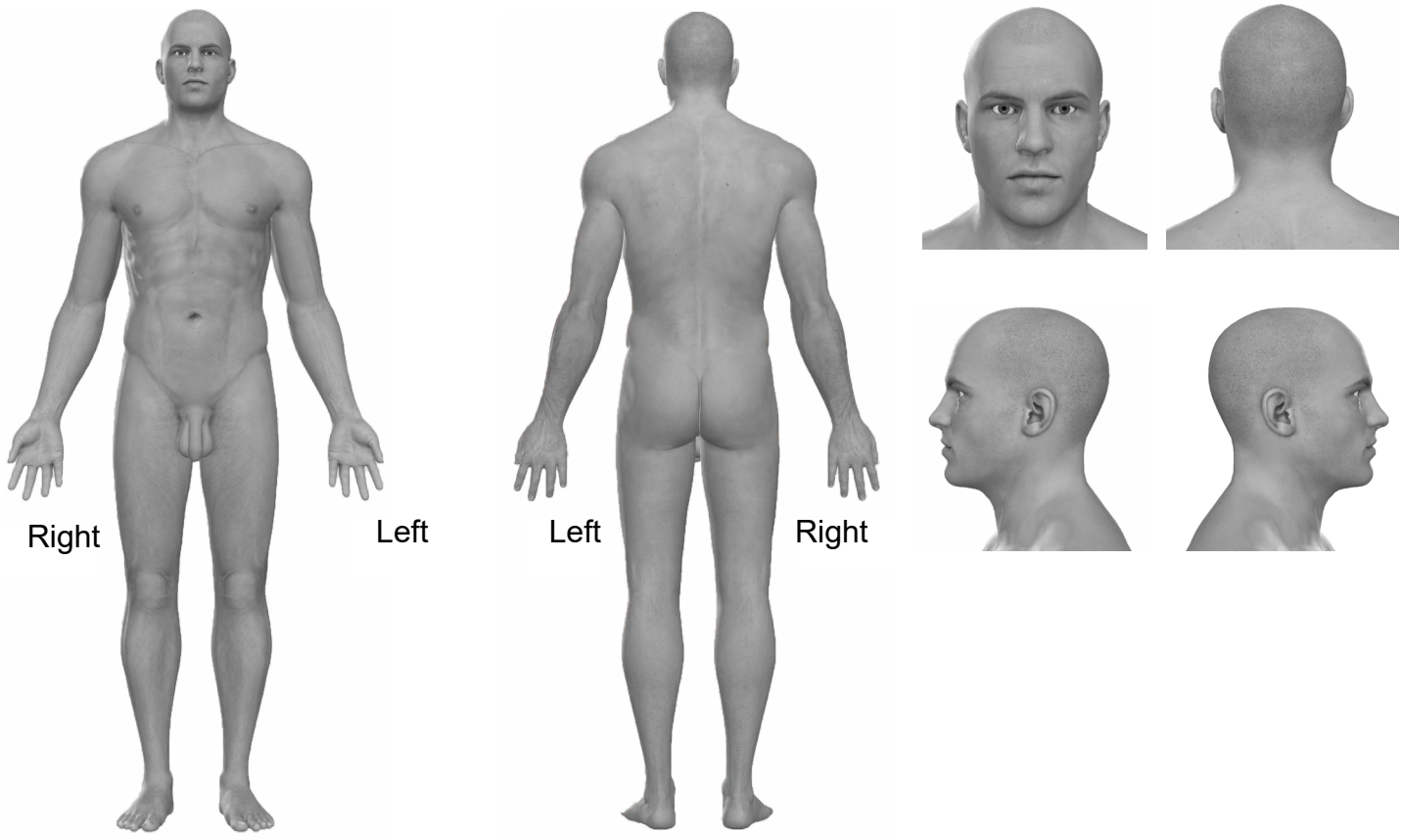
Pain history

1. Please indicate the location and type of your pain on the drawing below, using the following symbols. Please mark all affected areas.

Type of pain:

oooo Pins and Needles	xxxx Burning	//// Stabbing, Shooting
==== Numbness	:::: Dull Ache	^^^^ Tingling

If other, please specify:



2. When did the pain start?

3. How did the pain start (accidents/injuries: bike, car, motor vehicle, sport, other)?

4. Other previous accidents (that may or may not have caused any symptoms):

5. Please rate your pain between 1 and 10 (1: no pain, 10: unbearable).

Pain level now:

The lowest pain level in the last month:

The highest pain level in the last month:

6. What reduces your pain (massage, manual therapy, certain positions, medication, etc)?

7. What increases your pain (certain positions, movements, stress, etc)?

8. Please mark all your previous and current pain medications.

	Previous	Current
NSAID		
Diclofenac/Cataflam/Voltaren/Neodolpasse/Flector		
Ibuprofen/Advil/Algoflex/Brufen/Dolgit/Ibumax/Nurofen		
Naproxen/Apranax/Analgesin/Aleve/Naprosin		
Ketoprofen/Ketodex		
Nifluminsav/Donalgin		
Ketorolac		
Meloxicam/Movalis		
Nimesulide/Xilox		
Ketoprofen/Ketodex		
Paracetamol/Rubophen/Panadol/Curidol/Mexalen/Saridon/Zaldiar		
Other, please specify:		
Opioids		
Tramadol/Contramal/Zaldiar/Doreta/Curidol		
Morfin/MST/Sevredol		
Fentanyl/Durogesic/Matrifen		
Oxycodon/Oxycontin		
Buprenorphin/Transtec		
Hydromorphone/Jurnista		
Methadone		
Other, please specify:		
Spasmolytikum		
Pregabalin/Lyrica		
Gabapentin/Gabagamma		
Carbamazepin/Tegretol		
Oxcarbazepine/Trileptal		
Other, please specify:		
Neuroleptikum		
Klozapin/Leponex		
Aripiprazol/Anilify		
Kvetiapin/Ketilept/Seroquel		
Risperidon/Risperdal		
Chlorprothixene/Truxal		
Olanzapine/Zyprexa		
Other, please specify:		
Benzodiazepine		
Midazolam/Dormicum		

Alprazolam/Xanax, Frontin		
Clonazepam/Rivotril		
Other, please specify:		
TCA		
Amitriptyline/Teperinep/Triptafen		
Nortriptyline		
Mirtazapine/Mirtadepi/Mirzaten/Mizapin/Remeron		
Clomipramine/Anafranil		
Other, please specify:		
SSRI		
Fluoxetine/Prozac), fluvoxamine (Fevarin).		
Paroxetine/Seroxat/Paxil/Rexetin		
Sertralin/Zoloft/Sertadepi/Asentra/Serlift/Sertagen/Stimuloton		
Citalopram/Seropram/Celexa/Citalodep/Citapram		
Other, please specify:		
SNRI		
Duloxetin/Cymbalta/Dulcita		
Venlafaxin/Velaxin/Efectin/Effexor/Olwexya		
Other, please specify:		
Steroids		
Prednisolone/Medrol		
Other, please specify:		

9. What procedures or treatments have you had to relieve the pain? Did they help (physiotherapy, massage, acupuncture, steroid or other injections, surgeries)?

DATE	PROCEDURE	Improved	Worsened

Past medical and surgical history

10. Please list all internal medicine problems you have (high blood pressure, diabetes, arrhythmia, thyroid, etc).

11. Are you on any blood thinning medication or anticoagulants? Yes No

Please select checkbox below.

Aspirin, ASA, Astrix	
Clopidrogel/Atrombin, Clopidep, Clodidogrel, Egitromb, Kardogrel, Kerberan, Plagrel, Plavix, Trom-bex, Zyllt	

Ticlodipine/Ipaton, Ticlid	
Prasugrel/Efient	
Ticagrelor/Brilique	
Abciximab/Reopro	
Tirofiban/Aggrastat	
Eptifibatid/Integrilin	

Cangrelor/Kengreal	
Triflusal/Disgren	
Cilostazol/Antaclast, Cilozek, Noclaud	
Dipirydamol/Presantin, Asasantin	
Selexipag/Uptravi	
Dabigatran/Pradaxa	
Argatroban/Acova	
Lepirudin/Refludan	
Apixaban/Eliquis	
Edoxaban/Lixiana	

Fondaparinux/Arixtra	
Rivaroxaban/Xarelto	
Alteplase/Actilyse	
Acenocoumarol/Syncumar	
Warfarin/Warfarin, Marfarin	
Other, please specify:	

12. Please list all medications you take in addition to pain killers and blood thinners.

13. Do you smoke? Yes No If yes, how much per day?

14. Are you allergic to any medication?

Yes No

If yes, what are you allergic to?

Any other allergies?

15. Please list all previous procedures NOT related to the pain, and the date of procedure.

YEAR	PROCEDURE

16. Other review of systems, please select relevant checkboxes.

General condition

- General weakness and fatigue
- Weight gain of unknown origin
- Weight loss of unknown origin
- Lack of appetite
- Fever
- Night sweats
- Jaw pain
- Previously diagnosed cancer

Other:

Ear-nose-throat

- Hearing difficulty
- Sinusitis
- Running nose
- Tinnitus
- Dry mouth
- Loose teeth
- Earache
- Bleeding nose
- Sore throat
- Pain or numbness of face

Other:

Heart and vascular system

- Arrythmia
- Fast heartbeat
- Chest pain
- Edema
- Leg pain and swelling

Other:

Shortness of breath

- Night sweats
- Prolonged coughing
- Sneezing
- Phlegm
- Previously diagnosed tubercolosis
- Pleuritis
- Oxigen breathing support
- Blood in sputum when coughing
- Abnormal chest x-ray

Other:

Digestive system

- Heartburn
- Constipation
- Food intolerance
- Diarrhoea
- Abdominal pain
- Swallowing difficulty
- Nausea
- Vomiting
- Blood in stool

Other:

Urinary and reproductive system

- Painful urination
- Frequent urination
- Prostate problems
- Urinary bladder problems
- Impotence
- Urinary retention

Other:

Musculoskeletal system

- Joint pain
- Muscle pain
- Shoulder pain
- Knee, ankle, elbow, wrist pain
- Swollen joints
- Deformation of joints
- Back pain

Other:

Nervous system

- Frequent headache
- Double vision
- Weakness
- Paraesthesia
- Inbalance or difficulty walking
- Dizziness
- Tremor
- Consciousness
- Periodic loss of vision

Other:

Blood and lymp

- Hemophilia
- Anemia
- Leukemia
- Unknown swollen areas

Other:

Immune system

- Seasonal allergies
- Hay fever
- Itchiness
- Frequent infections
- HIV

Other:

Skin, hair, breast

- Permanent rash
- Itchiness
- Dry skin
- Hair loss
- Increased body hair
- Deformation of breast

Other:

Psychology and emotional wellbeing

- Insomnia
- Irritability
- Depression
- Anxiety
- Recurrent negativ thoughts
- Mood swings
- Hallucinations
- Compulsion
- Suicidal thoughts
- Unable to control emotions

Other:

Hormonal system

- Heat intolerance
- Cold intolerance
- Irregular periods
- Frequent hunger
- Frequent urination
- Frequent thirst
- Change in libido

Other:

Infectious diseases

- Hepatitis B, C
- HIV

Other:

Thank you for completing the Patient Form. Once you answered all questions, please save the form, and either bring it with you to your appointment, email it to: **fajdalomambulancia@mom-hospital.com** or click the SEND button below.

SEND

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MOM SZENT MAGDOLNA MAGÁNKÓRHÁZ