Patient Information Sheet

Thank you for contacting us and for your interest in stem cell therapy provided by **BAC Medical Tourism** and **Wu Medical Center (WMC)** in Beijing, China. We are happy to be able to help you.

Please find time to fill out the form below and email it back to us in a timely manner so that our medical experts at WMC can evaluate your conditions properly and provide you with our professional opinions including the treatment plan, the expected therapeutic outcome and the treatment cost.

Our policy is to always keep your personal information strictly confidential and we would never release it to a third party without your consent.

Patient Personal Information

<table>
<tr><td colspan="3">*Last Name:
*First Name:</td><td>Gender：</td></tr>
<tr><td>*Date of Birth:</td><td>*Age:</td><td>*Body Weight: (kg)</td><td>*Height: (cm)</td></tr>
<tr><td colspan="2" rowspan="5">Address:
Street:
City:
State/Province:
Country:
Postal Code:</td><td colspan="2">Home Phone:</td></tr>
<tr><td colspan="2">Office Phone:</td></tr>
<tr><td colspan="2">Cell Phone:</td></tr>
<tr><td colspan="2">Fax Number:</td></tr>
<tr><td colspan="2">*Email:</td><td colspan="2">Occupation:</td></tr>
</table>

Spouse / Parent / Guardian Information

<table>
<tr><td colspan="3">Last Name:
First Name:</td><td>Gender：</td></tr>
<tr><td colspan="2">Relationship to the patient:</td><td colspan="2">Email:</td></tr>
</table>

<table>
<tr><td colspan="2">Telephone：</td><td colspan="2">Fax：</td></tr>
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Patient Medical Information

Diagnosis and Date of Diagnosis
Current Symptoms and Physical Signs
(please describe in detail all of your current symptoms: (sensory/mobility/ performance of daily activities / speech / breathing / eating / metabolism / mental & emotional condition):
Current Medications
Results of Specific Examinations (MRI, CT, X-ray, EMG, etc.)
Please include the date of examination and availability of the results upon request. (Example: MRI scans taken / Images on CD can be sent upon request.)
Results of the Blood Test
(Date of examination /availability upon request / results attached can be on a separate document).

Do you have one or more of the following conditions? Please answer Yes or No
1. Heart disease: ___ 2. Hypertension: ___ 3. Diabetes: ___ 4. Pneumonia / sensitivity to pneumonia / pulmonary disease: ____ 5. Epilepsy or active seizures? ____ 6. Hypersensitive body constitution or history of severe allergies: ____ 7. Dependent on an inhalator or a pacemaker: : ____ 8. Complicated severe organic functional disturbances: ___ 9. Malignant tumors or coagulation disorders: ___ 10. Immune diseases:____ 11. Have you received surgery with a ventricular shunt? ____ 12. Do you have any infectious diseases such as HIV, RPR, A/B/C/D/E types of hepatitis, or active tuberculosis, etc.? ____
Additional Comments
(Other health conditions/previous treatments/ any information you think may be relevant for your evaluation)
How did you hear about us?

Date of filing: