Name :   Age / Sex :   /
Doctor :   MR No.:
Department :   Date of Visit:

Stem Cell Treatment - parkinson's - Adverse event report

Data Entered as of [   ] (dd/mm/yyyy) at Time [   ] Hours

Visit Details [   ]

ADVERSE EVENT REPORT

Type of adverse event (specify diagnosis, if possible)	Severity			Outcome of AE to date		Most likely cause of AE (disease; other illness, specify; concomitant treatment; other)
	Mild	Moderate	Severe	Yes	No	
Fever	☐	☐	☐	○	○	
Cough	☐	☐	☐	○	○	
Nausea	☐	☐	☐	○	○	
Vomiting	☐	☐	☐	○	○	
Wheezing	☐	☐	☐	○	○	
Itching	☐	☐	☐	○	○	
Constipation	☐	☐	☐	○	○	
Decreased appetite	☐	☐	☐	○	○	
Breathlessness	☐	☐	☐	○	○	
Worsening of symptoms	☐	☐	☐	○	○	
Inflammation	☐	☐	☐	○	○	
Other (specify)	☐	☐	☐	○	○	