The Kidney and Hypertension Center

Thank you for making your nephrology consultation appointment with our office, you have an appointment on ____________________ at ________am/pm at the above office location. Please fill out the following information to the best of your ability to help us with your registration process. Please bring this paperwork to your appointment along with your insurance cards, photo ID and medication list (to include name, strength and how often you take it).

NAME : ____ DATE OF BIRTH :__________________

SEX: M/F HOME PHONE:__________________________ CELL PHONE :______________________

REFERRING PHYSICIAN :_____________________ PRIMARY PHYSICIAN :______________________

Allergies: ____

____

Social History :

MARITAL STATUS: (circle one) Single Married Divorced Widowed
TOBACCO USE : (circle one) None Previous User Current User: ________pack(s)/day __________# of years
OTHER TOBACCO : (circle one) Pipe Cigar Chew Snuff
ALCOHOL USE : (circle one) None Yes: __________ number of drinks per week
DRUG USE : Any recreational drug use ? (circle one) None Previous User______ Yes: type __________________
CAFFEINE INTAKE: (circle one) None Coffee/Tea/Soda: _________number of cups/cans per day
DIET : Any specific diet ? (circle one) Diabetic Diet Calorie Restricted Low Fat
Low Sodium Low Potassium Low Sugar
Vegetarian Other:_______________________

EXERCISE : Any regular exercise ? (circle one) No Yes: what type____________________Days/week________

Family History:

PATIENT'S FATHER : (circle one) Living : Illnesses____

Deceased: Cause____

Health Status Unknown

PATIENT'S MOTHER: (circle one) Living: Illnesses____

Deceased: Cause____

Health Status Unknown

DOES ANY PERSON, BLOOD RELATED, HAVE ANY OF THE FOLLOWING :

		RELATION:			RELATION:
Hypertension	Y N	_______________	Kidney Disease	Y N	______________

Stroke	Y N	________________	Kidney Stones	Y N	_______________
Heart Attack	Y N	________________	Thyroid Problems	Y N	_______________
Heart Disease	Y N	________________	Urinary Problems	Y N	_______________
Congestive Heart Failure	Y N	________________	Blood/Protein in Urine	Y N	_______________
High Cholesterol	Y N	________________	Glaucoma	Y N	_______________
Diabetes	Y N	________________	ESRD/Dialysis	Y N	_______________
Cancer	Y N	________________	Other: (specify)__________________		

Type:__________________________________

Siblings: #___________

Children: #___________Healthy ? List any illnesses:____

____

Are you experiencing any of the following symptoms ? (circle those that apply)

General	*Cardiac*	*Musculoskeletal*	*Skin*
-Decreased energy level	-Chest pain	-Joint pain	-Rash
-Decreased appetite	-Palpitations	-Swelling	-Burning
-Weight gain	*Gastrointestinal*	*Neurological*	
-Weight loss	-Abdominal pain	-Dizziness	
Eyes/Ears	-Nausea	-Seizures	
-Vision changes	-Vomiting	*Endocrinology*	
-Hearing loss	*Genitourinary*	-Temperature intolerance	
Respiratory	-Painful urination	-Frequent urination	
-Cough	-Blood in urine	*Blood/Lymphatic*	
-Blood in sputum	-Nighttime urination	-Anemia	
	-Urgency	-Easy bruising	

Medications:

It is very important for us to have the most accurate medication information possible. Please include all prescriptions, non-prescriptions, vitamins, home remedies, birth control, herbs, etc.

Medication	Dose (e.g. mg/pill)	Times Per Day