Nephrology Associates, PC
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New Patient Information

(PLEASE PRINT CLEARLY)

Full Legal Name: _____ Date of Birth: _____

Preferred Name (nickname): _____SS#_____ Gender: _____

Address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Would you like to receive text messages?__yes__no Cellphone Provider: _____

Email Address: _____

You will receive an email with your Patient Portal Information used to communicate with our office.

Preferred Pharmacy: _____ Phone Number: _____

Address: _____

Name of Insurance Company: _____

If other than patient, Policy Holder Name: _____ Date of Birth: _____

Relationship to patient _____Policy Number: _____ Group Number_____

Do you have any additional health insurance coverage? ___ yes ___ no

Name of Insurance Company: _____

If other than patient, Policy Holder Name: _____ Date of Birth: _____

Relationship to patient _____Policy Number: _____ Group Number_____

Referring Physician: _____ Primary Care Physician: _____

Do you have any medical devices or home oxygen? Yes___ No___Please Specify _____

Are you ALLERGIC to any medications? Yes ___ No ___ list: _____

Marital status ___ Married ___Single ___ Divorced ___ Separated___ Widow/er

Tobacco use: ___ None Packs per day ___ Started (age) ___ Stopped (age) ___

Alcohol Use: ___ None Drinks per day ___

Exercise habits: ___ No regular program ___ Regular program – describe_____

Special diets: ___Yes ___ No Please describe: _____

Occupation: _____ If retired, previous occupation: _____

Educational Level: ___ Elementary ___ Middle___ High___College Undergraduate___ Masters ___ Doctorate

Medication	Dose	Directions

PLEASE BRING ALL OF YOUR MEDICATION BOTTLES TO YOUR APPOINTMENT

Surgeries and Hospitalizations

Surgery/Hospitalization	Date & Location

Past Medical History

Please check if you had any of the following:

- ☐ Mumps
- ☐ Chicken Pox
- ☐ Chorea
- ☐ Heart Disease
- ☐ Gallbladder Attacks
- ☐ Diabetes Mellitus
- ☐ Cancer
- ☐ Rheumatism
- ☐ Colitis
- ☐ Venereal Disease
- ☐ Injuries
- ☐ Muscular Dystrophy
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ High Blood Pressure
- ☐ Convulsions
- ☐ Arthritis
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Broken Bones
- ☐ High Blood Sugar
- ☐ Mononucleosis
- ☐ Scarlet Fever
- ☐ Bright's Disease
- ☐ Yellow Jaundice
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Blood Transfusion

Previous Medical Exams

- ☐ EKG
- ☐ Colonoscopy
- ☐ Upper GI Scope
- ☐ Sigmoidoscopy
- ☐ Diabetes Study
- ☐ Eye
- ☐ Ear
- ☐ Chest Xray
- ☐ Joint Xray
- ☐ Blood Transfusion
- ☐ Other Test or Xray

_____

_____

_____

_____

_____

Year of Immunization for

Small Pox _____

Measles _____

Tetanus _____

TB Skin Test _____

Family History

Relative		**Age**	**Cause of Death, If Deceased**	**Major Illness**
Father				
Mother				
Brother	**Sister**			
Son	**Daughter**			

Have you ever had any imaging (CT, ULTRASOUND, MRI, etc.) of your kidneys or abdomen?

When / Where _____

Review of Systems:

Current Weight: _____ Has your weight significantly changed recently? Gain/Loss How much? _____

Skin:

- ☐ Have you ever seen a dermatologist?
- ☐ Have you had any changes in the color or texture of your skin?
- ☐ Are you bothered by severe itching?
- ☐ Have you had skin cancer?
- ☐ Have you ever had hives?

Hemotologic:

- ☐ Have you been treated for severe anemia (low blood)?
- ☐ Do you or does anyone in your family have a bleeding or clotting disorder?
- ☐ Do you have any enlarged lymph glands?
- ☐ Have you ever had a bone marrow test?
- ☐ Have you ever been told you could not donate blood?

Head/Ears/Nose/Throat:

- ☐ Is your eyesight getting worse?
- ☐ Do you ever see double?
- ☐ Do you have other eye problems?
- ☐ Do you have glaucoma?
- ☐ Are you hard of hearing?
- ☐ Have you ever had severe or recurrent ear infections?
- ☐ Have you had mastoiditis or a mastoid operation?
- ☐ Do you have constant noises in your ears?
- ☐ Do you get hay fever?
- ☐ Have you ever had sinusitis?
- ☐ Have you had bad nosebleeds?
- ☐ Do you have false teeth?
- ☐ Do you have trouble with your gums?
- ☐ Do you often have toothaches?
- ☐ Do you frequently get a sore throat?
- ☐ Do you frequently get hoarse?

Respiratory/Cardiovascular:

- ☐ Do you frequently have bronchitis?
- ☐ Have you ever had asthma?
- ☐ Do you have a chronic cough?
- ☐ Do you cough up phlegm every day? Color _____ Amount _____
- ☐ Have you ever coughed up blood?
- ☐ Do you have severe sweating at night?
- ☐ Have you ever had a chronic lung condition?
- ☐ Have you ever had Tuberculosis?
- ☐ Has a doctor said you have high blood pressure?
- ☐ Have you ever taken medication for high blood pressure?

- ☐ Do you get tightness, pressure, squeezing or burning in your chest during exertion or at meals?
- ☐ Do you have palpitations or does your heart beat irregular or too fast?
- ☐ Have you ever taken Nitroglycerin?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath while sitting still?
- ☐ Do you have difficulty breathing while lying flat?
- ☐ Do you have a heart murmur?
- ☐ Do you have an enlarged heart?
- ☐ Do you have varicose veins?
- ☐ Do you get severe pain in your legs when walking?
- ☐ Do you ever have swollen feet or ankles?

Gastrointestinal:

- ☐ Is your appetite excessive?
- ☐ Is your appetite poor?
- ☐ Do you often suffer from upset stomach?
- ☐ Is it difficult or painful to swallow?
- ☐ Do you feel bloated after eating?
- ☐ Do you belch a lot after eating?
- ☐ Do you have heartburn?
- ☐ Do you have indigestion?
- ☐ Do you have severe pains in your stomach?
- ☐ Have you ever vomited blood?
- ☐ Have you had stomach ulcers?
- ☐ Were ulcers found by xray exam? When _____ Where _____
- ☐ Have you ever had blood in your stool?
- ☐ Are you stools ever black?
- ☐ Do you have frequent, loose bowel movements?
- ☐ Do you have pain with bowel movements?
- ☐ Do you have severe constipation?
- ☐ Have you had a recent change in your bowel habits?
- ☐ Have you ever had hemorrhoids?
- ☐ Have you ever had jaundice (yellow eyes and skin)?
- ☐ Have you ever had serious liver or gallbladder problems?

Genitourinary:

- ☐ Were you ever treated for venereal disease?
- ☐ Do you get up frequently at night to urinate? How many times _____
- ☐ Do you urinate frequently during the day?
- ☐ Do you have pain, burning, or stinging when you urinate?
- ☐ Do you sometimes lose control of your bladder?
- ☐ Has your urine ever been brown, black, or bloody?
- ☐ Has a doctor ever said you have kidney or bladder disease?
- ☐ Have you had kidney stones or colic?
- ☐ Have you had any problems with sexual intercourse?

Musculoskeletal:

- ☐ Are your joints ever painfully swollen?
- ☐ Do your muscles and joints often feel stiff or hot?
- ☐ Do pains in the back make it hard for you to keep up with your work?
- ☐ Have you ever had muscle weakness?
- ☐ Have you ever had sciatica or lumbago?
- ☐ Do you have any muscle tenderness?

Constitutional:

- ☐ Do you have frequent severe headaches?
- ☐ Do you frequently feel faint?
- ☐ Have you fainted more than twice in your lifetime?
- ☐ Do you have constant numbness or tingling in any part of your body?
- ☐ Was any part of your body paralyzed or partially paralyzed?
- ☐ Have you ever had a stroke?
- ☐ Did you ever have a seizure?
- ☐ Do you have frequent crying spells?
- ☐ Do you have difficulty sleeping at night?
- ☐ Do you get depressed?
- ☐ Have you ever seriously considered suicide?
- ☐ Are you nervous?
- ☐ Have you been hospitalized for your nerves?
- ☐ Do you have loss of memory?
- ☐ Have you ever sought or desired psychiatric help?

Edodocrine:

- ☐ Do you have diabetes?
- ☐ Did a doctor ever say you had a goiter or thyroid trouble?
- ☐ Are you intolerant of heat or cold?
- ☐ Do you pass more urine than before?
- ☐ Are you constantly thirsty?
- ☐ Have you had any changes in your hair growth?
- ☐ Have you had radiation to your neck?

FOR MEN

- ☐ Have you ever had anything wrong with your genitals?
- ☐ Have you ever had a hernia?
- ☐ Do you have trouble starting or stopping your stream?
- ☐ Do you have a weak stream?
- ☐ Do you have prostate trouble?
- ☐ Have you had a vasectomy?

FOR WOMEN

- ☐ Do you bleed between periods?
- ☐ Do you have symptoms of menopause?
- ☐ Have you taken female hormones?
- ☐ Have you had bleeding since menopause?
- ☐ Have you had lumps or tumors in your breasts?
- ☐ Have you had blood or discharge from your nipples?
- ☐ Do you have pain or tenderness in your breasts?

Age at first menstruation _____
Date of last Pap Smear _____
Date of last Mammogram _____