Clinical Renal Associates, LTD

Medications (please include vitamins, supplements, herbals, and over the counters): Name					3.	3IN://		
Cay Same Cay Cay	r: Male Fen	ıale		Da	Date of Birth://			
Prone: Home - Work - Relationship - Phone - Referring Physician: Reason for Referral: Primary Care Physician: Name - Phone: Primary Care Physician: Name - Phone: Address: Other physicians you would like us to know about or send letters to? Name: Phone: Type of Physician: Name: Phone: Type of Physician: Address: Other Same Medications (please include vitamins, supplements, herbals, and over the counters): Name Dose Frequency Name Dose Frequency 11 1 12	ss:					City	State	Zip
Regency Contact: Name	Home		_ Work	Cell -				
Address:								
rrinary Care Physician: Name	ng Physician:							
rimary Care Physician: Name	ı for Referral:							
Other physicians you would like us to know about or send letters to? Itame:						Phone:		
Other physicians you would like us to know about or send letters to? Jame:	ss:							Zip
Address:					_ Type of Physician:_		State	Z1p
Name	ss:					City	State	Zip
Address: Phone:								Ζiμ
Name:			Phone:		Type of Physici	an:		
Medications (please include vitamins, supplements, herbals, and over the counters): Name Dose Frequency Name Dose Frequency 11 12 13 14 15 16 17 18 18 19 O Allergies (Please list reaction) Penicillin Sulfa Other Sulfa Other Latex Other Latex Family History Medications (please include vitamins, supplements, herbals, and over the counters): Allergies (Please list reaction) Family History Mother: Alive Deceased Medical Problems Other Salive Deceased Medical Problems Deter family history (Please indicate relationship to you and age at which occurred):	SS:					City	State	Zip
Medications (please include vitamins, supplements, herbals, and over the counters): Name Dose Frequency Name Dose Frequency 11 12 13 14 15 16 177 18 19 O 20 Allergies (Please list reaction) Sulfa Other Sulfa Other Iodine/Contrast Latex Family History Mother: Alive Deceased Medical Problems Other Salive Deceased Medical Problems	:		Phone:		Type of Physic	ian:		
Name Dose Frequency Name Dose Frequency	ss:					City	State	Zip
11 12 13 14 15 16 17 18 19 O		Medica	ations (please include vitamin	ıs, supplements, herba	ls, and over the counte	ers):		
12	Name	Dose	Frequency		Dose	F	requency	
13								
14								
15	+							
16								
17				_				
18								
Penicillin Sulfa Iodine/Contrast Latex Mother: Alive Deceased Medical Problems Family History Other Family History								
Allergies (Please list reaction) Penicillin Sulfa Iodine/Contrast Latex Other Family History Other Family History Other Other Other Other Other Other Other Family History								
Allergies (Please list reaction) Penicillin Other Sulfa Other Iodine/Contrast Latex Other Family History Mother: Alive Deceased Medical Problems Father: Alive Deceased Medical Problems Other Other Family History Other Other Family History							-	
Penicillin Other Sulfa Other Iodine/Contrast Other Latex Other Mother: Alive Deceased Medical Problems Family History Other Alive Deceased Medical Problems Family History Other Alive Deceased Medical Problems Other family history (Please indicate relationship to you and age at which occurred):			Allergies					
Iodine/Contrast Latex Other Family History Iother: Alive Deceased Medical Problems ather: Alive Deceased Medical Problems Other family history (Please indicate relationship to you and age at which occurred):	nicillin		,c. gres	,				
Latex Other Family History Nother: Alive Deceased Medical Problems Alive Deceased Medical Problems Other family history (Please indicate relationship to you and age at which occurred):				Other				
Family History 10ther: Alive Deceased Medical Problems ather: Alive Deceased Medical Problems Other family history (Please indicate relationship to you and age at which occurred):								
10ther: Alive Deceased Medical Problems	.ex							
ather: Alive Deceased Medical Problems Other family history (Please indicate relationship to you and age at which occurred):				mily History				
Other family history (Please indicate relationship to you and age at which occurred):								
		e muicate relations	iip to you and age at which occuri	rea): Diabete	ec.			
idiney blease Stoke Stoke								
Heart Disease Cancer	Disease			-				
ligh Blood Pressure Other								

Past Medical History

Patient Name (Please mark if you currently or previously had any of the following) <u>Cardiovascular</u> High blood pressure Heart disease Arrhythmia (irregular heart rhythm) ☐ Pacemaker placement Prior angiogram (cardiac cath) Defibrillator (AICD) placement Angioplasty (balloon) or stents placed Open heart surgery High cholesterol ☐ Heart valve problems or replacements ☐ Heart attack ☐ Rheumatic heart disease ☐ Congestive heart failure (CHF) Other heart problems Pulmonary COPD (emphysema or chronic bronchitis) Use oxygen at home ☐ Asthma Pneumonia ☐ Sleep apnea ☐ Other lung disease_ Use BiPap, CPAP or oxygen at night Endocrine: Diabetes On insulin Diabetic retinopathy (diabetic eye disease) Diabetic neuropathy (numbness, burning or poor sensation in feet) ☐ Thyroid disease ☐ Other: Gastrointestinal: Peptic ulcer disease (stomach or intestinal ulcer) Crohn's disease Gastric bypa: Gallstones or Pancreatitis Gastric bypass (weight loss surgery) Gallstones or gallbladder disease Ulcerative colitis ☐ Irritable bowel syndrome ☐ Diverticulosis or diverticulitis Hepatitis or any liver disease ☐ Hemorrhoids ☐ Bowel obstruction Other: Genitourinary: Enlarged prostate Prostate surgery ☐ Kidney (renal) failure Enlarged prostate (BPH) ☐ Required dialysis in past? ☐ Erectile dysfunction (ED) ☐ Kidney stones Fibroids Ovarian Ovarian cysts a Other ☐ Blood in urine ☐ Urinary tract infection Other Kidney infection Previous kidney transplant Aortic aneurysm Peripheral vascular disease (PAD, PVD, poor circulation in legs) ☐ Other vascular disease Neurologic: Seizure Loss of consciousness ☐ Stroke or warning stroke Other: Psychiatric: Depression ☐ Anxiety ■ Bipolar disorder Other Hematology/Oncology:

☐ Cancer

☐ Other

Anemia

☐ Prior blood transfusion

☐ Blood clots (DVT or PE) in legs or lungs

Past Medical History – Page 2 Patient Name ____

Tatient Name		
Rheumatology		
	Arthritis (Osteoarthristis)Joint Disease	
\square Sjogren's \square .	Joint Replacement(s)	
□ Scleroderma □	Gout	
☐ Mixed connective tissue disease ☐ ☐	Fibromyalgia	
	Other	
Infectious Disease		
☐ Tuberculosis		
☐ Hepatitis B	☐ HIV/AIDS	
☐ Hepatitis C	☐ Other	
<u>Immunizations</u>		
☐ Hepatitis A	□ Pneumovax	
□ Hepatitis B	☐ Influenza (flu shot)	
<u>Vision.Hearing</u>		
□ Cataracts	☐ Hearing Loss	
□ Glaucoma	□ Other	
Other Medical History		
1	4	
2	5	
3	6	
Past Surgeries		
Procedure Date 1	Procedure Date	
1	Procedure Date 4	
2	5	
3	6.	
Marital Status Social	History Highest Education	
□ Single □ Widowed	☐ Grade School (K-8) ☐ College Grad	uate
□ Divorced □ Married	☐ High School (9-12) ☐ Post-College	
☐ Separated	☐ Some College Graduate D	egree
Children	Employment: Occupation:	
☐ Yes (Indicate age/gender)	☐ Employed ☐ Unemployed	
□ No	☐ Employed ☐ Unemployed ☐ Retired ☐ On Disability	
	□ Student	
Living Alone:	- Student	
Tobacco:		
□ Never Smoked □ Quit: When:How long were you smo	king years How many cigarattes/day	
☐ Still smoking ☐ Still smoking ☐ Still smoking ☐ How long have you been smo	kingyears How many cigarettes/day	
Alcohol:		
Never Rare Social/Occasional	Frequentdrinks/week	
icit Drugs:		
	0 '- 111	
□ Never □ Previously Used: Drug(s)	Quit When:	