Clinical Renal Associates, LTD

Name:_____ SSN: ____/___/_____

Gender: Male Female Date of Birth:___/___/____

Address:_____
City State Zip

Phone: Home - _____ Work - _____ Cell - _____

Emergency Contact: Name - _____ Relationship - _____ Phone - _____

Referring Physician: _____

Reason for Referral:_____

Primary Care Physician: Name - _____ Phone: _____

Address: _____
City State Zip

Other physicians you would like us to know about or send letters to?
Name:_____Phone: _____ Type of Physician:_____

Address:_____
City State Zip

Name:_____Phone: _____Type of Physician:_____

Address:_____
City State Zip

Name:_____Phone: _____ Type of Physician:_____

Address:_____
City State Zip

Medications *(please include vitamins, supplements, herbals, and over the counters):*

Name	Dose	Frequency	Name	Dose	Frequency
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

Allergies *(Please list reaction)*

Penicillin _____ Other _____
Sulfa _____ Other _____
Iodine/Contrast _____ Other _____
Latex _____ Other _____

Family History

Mother: Alive Deceased Medical Problems_____
Father: Alive Deceased Medical Problems_____
Other family history *(Please indicate relationship to you and age at which occurred):*
Kidney Disease _____ Diabetes_____
Kidney Stones _____ Stoke _____
Heart Disease _____ Cancer _____
High Blood Pressure _____ Other_____

Past Medical History

Patient Name _____

(Please mark if you currently or previously had any of the following)

Cardiovascular

- ❒ High blood pressure
- ❒ Heart disease
- ❒ Prior angiogram (cardiac cath)
- ❒ Angioplasty (balloon) or stents placed
- ❒ Open heart surgery
- ❒ Heart attack
- ❒ Congestive heart failure (CHF)
- ❒ Arrhythmia (irregular heart rhythm)
- ❒ Pacemaker placement
- ❒ Defibrillator (AICD) placement
- ❒ High cholesterol
- ❒ Heart valve problems or replacements
- ❒ Rheumatic heart disease
- ❒ Other heart problems_____

Pulmonary

- ❒ COPD (emphysema or chronic bronchitis)
- ❒ Use oxygen at home
- ❒ Sleep apnea
- ❒ Use BiPap, CPAP or oxygen at night
- ❒ Asthma
- ❒ Pneumonia
- ❒ Other lung disease_____

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)
- ❒ Gastric bypass (weight loss surgery)
- ❒ Gallstones or gallbladder disease
- ❒ Pancreatitis
- ❒ Hepatitis or any liver disease
- ❒ Bowel obstruction
- ❒ Crohn's disease
- ❒ Ulcerative colitis
- ❒ Irritable bowel syndrome
- ❒ Diverticulosis or diverticulitis
- ❒ Hemorrhoids
- ❒ Other: _____

Genitourinary:

- ❒ Kidney (renal) failure
- ❒ Required dialysis in past?
- ❒ Kidney stones
- ❒ Blood in urine
- ❒ Urinary tract infection
- ❒ Kidney infection
- ❒ Previous kidney transplant
- ❒ Enlarged prostate (BPH)
- ❒ Prostate surgery
- ❒ Erectile dysfunction (ED)
- ❒ Fibroids
- ❒ Ovarian cysts *a* Other
- ❒ Other_____

Vascular:

- ❒ 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
- ❒ Bipolar disorder
- ❒ Anxiety
- ❒ Other_____

Hematology/Oncology:

- ❒ Anemia
- ❒ Prior blood transfusion
- ❒ Blood clots (DVT or PE) in legs or lungs
- ❒ Cancer
- ❒ Other_____

Past Medical History – Page 2

Patient Name _____

Rheumatology

- □ Lupus
- □ Sjogren's
- □ Scleroderma
- □ Mixed connective tissue disease
- □ Rheumatoid arthritis
- □ Arthritis (Osteoarthristis)Joint Disease
- □ Joint Replacement(s)
- □ Gout
- □ Fibromyalgia
- □ Other

Infectious Disease

- □ Tuberculosis
- □ Hepatitis B
- □ Hepatitis C
- □ HIV/AIDS
- □ Other _____

Immunizations

- □ Hepatitis A
- □ Hepatitis B
- □ Pneumovax
- □ Influenza (flu shot)

Vision.Hearing

- □ Cataracts
- □ Glaucoma
- □ Hearing Loss
- □ Other

Other Medical History

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Past Surgeries

	Procedure	Date		Procedure	Date
1.			4.		
2.			5.		
3.			6.		

Marital Status

- □ Single
- □ Divorced
- □ Separated
- □ Widowed
- □ Married

Social History

- □ Grade School (K-8)
- □ High School (9-12)
- □ Some College

Highest Education

- □ College Graduate
- □ Post-College Graduate Degree

Children

- □ Yes (Indicate age/gender) _____
- □ No

Employment: Occupation: _____

- □ Employed
- □ Unemployed
- □ Retired
- □ On Disability
- □ Student

Living Alone: □ Yes □ No

Tobacco:

□ Never Smoked □ Quit: When:_____How long were you smoking ____years How many cigarettes/day _____

□ Still smoking How long have you been smoking ____years How many cigarettes/day _____

Alcohol:

Never Rare Social/Occasional Frequent_____drinks/week

Illicit Drugs:

□ Never □ Previously Used: Drug(s) _____Quit When:_____

□ Currently using: Drugs(s)_____