ADVANCED NEPHROLOGY & HYPERTENSION
Kidney Care Starts Here

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Dear New Patient:

Welcome to our practice. We are very pleased that you have selected us for your medical care. Enclosed are forms for you to fill out **in advance** of your appointment to assist Advanced Nephrology and Hypertension in making sure that we have all the information necessary to provide you with quality care and treatment. Please fill out all the forms completely in black ink and bring all insurance cards, drivers' license and most importantly a list of **ALL YOUR MEDICATIONS**. You may also bring your medication bottles with you if it is convenient for you. If you have any questions or problems filling out the forms, do not hesitate to call so that we may assist you.

Please arrive 30 min prior to your appointment bringing with you all forms, insurance cards and medications. This will help prevent any delay in your visit time.

If you have been treated by a physician or hospital recently please notify the staff prior to the visit so we can contact the appropriate facility and obtain any medical records that will assist the physician with your care.

Once again, welcome to our practice. We look forward to providing you with quality care.

Sincerely,

Advanced Nephrology and Hypertension

ADVANCED NEPHROLOGY & HPERTENSION

PATIENT REGISTRATION FORM

Patient Name: _____ Date: _____

Address: _____ City: _____ State/Zip: _____

Birthdate: _____ Marital Status: _____ SS#: _____

Phone (H) _____ Phone (C) _____ Phone (W) _____

Referring Dr. _____ Family Dr. _____

Emergency Contact: _____ Phone: _____

PLEASE CIRCLE WHICH APPLIES BEST

Race: American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
Decline
White

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Decline

Preferred Language: English Spanish Other: _____

Need Translation: Y/N

Smoker Y/N **Quantity:** _____

Name of Preferred Pharmacy: _____

Name of most commonly use Laboratory: _____

Primary Insurance Info:

Insurance Name: _____ Co-Pay _____

Card Holders Last Name: _____ First: _____ MI: _____

Birthday: _____ SS#: _____ Gender M/F Home/Cell Phone: _____

Address: _____ City, State, Zip: _____

Secondary Insurance Info:

Insurance Name: _____ Co-Pay _____

Card Holders Last Name: _____ First: _____ MI: _____

Birthday: _____ SS#: _____ Gender M/F Home/Cell Phone: _____

Address: _____ City, State, Zip: _____

Patient Signature _____ Date: _____

PATIENT HISTORY FORM

NAME:_____ DOB___/___/_____ AGE_____ DATE_____

MEDICAL HISTORY

DO YOU HAVE (PLEASE CIRCLE)?

KIDNEY DISEASE:

Have you ever been told you had kidney disease or had to see a nephrologist or urologist before?	No	Yes
Have you ever had a kidney biopsy?	No	Yes
Have you ever been told you had blood or protein in your urine before?	No	Yes
Have you ever had a kidney stone?	No	Yes
Have you ever had surgery on your kidneys, urinary bladder, or prostate?	No	Yes

DIABETES:

Have you been told you had diabetes?	No	Yes
If yes, how long ago was it diagnosed?	_____	
Do you take insulin?	No	Yes
Do you check your blood sugar?	No	Yes
Do you see an eye specialist for diabetes?	No	Yes
Have you had a procedure to treat diabetic eye disease?	No	Yes

HIGH BLOOD PRESSURE

Have you ever been told you have high blood pressure?	No	Yes
If yes, how long ago?	_____	
Do you take BP medicine?	No	Yes
If yes, how long ago was it first prescribed?	_____	
Have you ever been hospitalized or in the emergency room due to high blood pressure?	No	Yes
Do you check your BP?	No	Yes
If so what are your average BP readings?	_____	

Please describe if you have had any blood pressure medications you have not tolerated well or reacted poorly with.

_____

_____

ILLNESSES: PLEASE PLACE A CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING:

Heart Attack_____	Congestive Heart Failure_____	Pacemaker/Defibrillator_____
Chest Pain_____	Stroke_____	Seizures_____
Pneumonia_____	Chronic Lung Disease_____	Asthma_____
Cancer_____	Liver Disease_____	Anemia_____
Blood Transfusion_____	Depression_____	Blood Clots/Clotting_____
Stomach/Intestinal Disorders_____		

NAME: _____ DOB:_____

FEMALE PATIENTS:
#of pregnancies____ #of children____

Have you been treated for high blood pressure, toxemia, or ecclampsia/ preeclampsia with your pregnancies? No Yes

SURGICAL HISTORY:

Surgery_____Year_____Hospital_____

Surgery_____Year_____Hospital_____

Surgery_____Year_____Hospital_____

Surgery_____Year_____Hospital_____

****Please use other side of sheet to list additional Surgeries if needed**

PERSONAL HISTORY:

Single_____ Married_____ Divorced_____ Widowed_____

Live alone? Yes / No Live with_____

Employment: Are you currently working? No Yes
If you are currently employed, what is your job? _____

Diet: Regular____ Low Salt____ Vegetarian:_____
Foods told to avoid by physicians?_____

Most Meals are: Cooked at home___/per week Eaten out___/per week (restaurants) Eaten out___/per week (fast food)

Do you? Smoke: No Previously Currently

Usage of tobacco: ____ packs per day for ____ years

Drink Alcohol : No Previously Currently

I currently have ____drink(s) per day/week

Drink Caffeine: No Yes ____cup(s) coffee/tea/soda per day

Exercise: No Yes ____times per week

FAMILY HISTORY:,

Have any relatives (especially parents, brothers and sisters, your children) been told that they have kidney disease? No Yes

If yes, please explain:

_____

NAME:_____ DOB:_____

MEDICATIONS:

(Please note that it is very important to us to have a thorough and accurate list of your medications at each and every visit, including the names of medications that have recently changed or been stopped / started, including over-the-counter medications)

Medication	Dose	Frequency
(example) Aspirin	325 mg	1 x per day

ALLERGIES: Please list all medication/environmental allergies, use other side of sheet to list additional medications or allergies if needed

I have no allergies._____

Allergen	Reaction
(Example) Penicillin	(Example) Hives

NAME:_____ DOB:_____

PLEASE CIRCLE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Fevers
Chills
Recent Weight Loss or Gain
Night Sweats

Vision Impairment
Eye Pain
Cataracts

Sore Throat
Ear Pain
Nose Bleeds
Sinus Symptoms

Chest Pain
Palpitations
Swelling in feet or ankles
Difficulty breathing lying down

Shortness of Breath
Cough
Cough productive of blood
Wheezing

Abdominal Pain
Difficulty swallowing
Nausea
Vomiting
Diarrhea
Constipation

Falls
Arm or Leg Pain
Arthritis
Back Pain
Joint Pain

Rash
Bruising
Itching

Headache
Dizziness
Numbness

Depression
Anxiety
Insomnia

Heat or Cold Intolerance
Hair Loss

Discharge from breasts
Bleeding Gums
Lumps in breast

For the next questions, please answer on a scale of 0-5, using the following ranking:

0=Not at all **3=About half of the time**
1=Less than 1 time in 5 **4=More than half of the time**
2=Less than half of the time **5=Almost all of the time**

Over the past month, how often have you had a feeling of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you stopped and started again several times when you urinated?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times did you usually get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5
Over the past month how many times did you have blood in your urine?	0	1	2	3	4	5

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SPRINGFIELD, OHIO 45503

PHONE (937)322-7521

FAX (9370322-4047

I, _____, give the office of **Advanced Nephrology & Hypertension, LLC** permission to release my medical information to the following family members, friends, etc.

I understand that this will stay in effect until I initiate a change.

_____	_____	_____
Authorized to receive information	Relationship	Phone

_____	_____	_____
Authorized to receive information	Relationship	Phone

_____ _____

Signature of Patient Date

Other Comments: