



**Patient History**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_ PATIENT PHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

INSURANCE NAME: \_\_\_\_\_ SUBSCRIBER NUMBER: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ EMERGENCY CONTACT PHONE: \_\_\_\_\_

PREFERRED LANGUAGE: \_\_\_\_\_ INTERPRETER NEEDED?  YES  NO

PHARMACY NAME/CROSSROADS: \_\_\_\_\_

PRIMARY CARE PHYSICIAN (PCP): \_\_\_\_\_ PHONE: \_\_\_\_\_

PCP ADDRESS: \_\_\_\_\_ FAX: \_\_\_\_\_

PREFERRED LABORATORY/CROSSROADS: \_\_\_\_\_

PREFERRED IMAGING FACILITY/CROSSROADS: \_\_\_\_\_

Do you see other providers/specialists? If yes, please write their names and specialty below:

\_\_\_\_\_

RACE/ETHNICITY	
RACE	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer
ETHNICITY	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Decline to Answer
MEDICATION ALLERGIES	
Please list names of medications with specific allergy or reaction that you have experienced.	
DRUG NAME	ALLERGY or REACTION
Have you ever experienced a reaction when given X-ray dye or IV Contrast?	
<input type="checkbox"/> No <input type="checkbox"/> Yes, please identify reaction:	
FOOD ALLERGIES	
Please list the foods with the specific allergy or reaction that you have experienced.	
FOOD	ALLERGY or REACTION

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<b>MEDICATION LIST</b> <b>**Please bring a list/bottles of your current medications**</b>		
DRUG/SUPPLEMENT/VITAMIN NAME	STRENGTH (mg)	FREQUENCY

<b>NSAID HISTORY</b> <b>Are you currently, or have you taken any of the following medications in the past?</b>		
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<input type="checkbox"/> Advil/Co-Advil	<input type="checkbox"/> Disalcid	<input type="checkbox"/> Mefenamic/Ponstel
<input type="checkbox"/> Aleve/Anaprox/Naprosyn/Naproxen	<input type="checkbox"/> Empirin/Genprin	<input type="checkbox"/> Meloxicam/Mobic
<input type="checkbox"/> Ansaid	<input type="checkbox"/> Etodolac/Lodine	<input type="checkbox"/> Midol-IB/Pamprin-IB
<input type="checkbox"/> Arthrotec/Cataflam/Diclofenac/Voltaren	<input type="checkbox"/> Feldene/Piroxicam	<input type="checkbox"/> Ponstel
<input type="checkbox"/> Aspirin/Easprin/Ecotrin/Zorprin	<input type="checkbox"/> Fenoprofen/Nalfon	<input type="checkbox"/> Relafen
<input type="checkbox"/> Baclofen/Kemstro/Lioresal	<input type="checkbox"/> Flurbiprofen	<input type="checkbox"/> Robaxin
<input type="checkbox"/> Bextra	<input type="checkbox"/> Halfprin/Iburin	<input type="checkbox"/> Salsitab
<input type="checkbox"/> Butazolidin	<input type="checkbox"/> Ibuprofen/Motrin/Rufen/Trendar/Medipren	<input type="checkbox"/> Sulindac/Clinoril
<input type="checkbox"/> Celebrex/Celecoxib	<input type="checkbox"/> Indocin/Indomethacin/Rheumacin	<input type="checkbox"/> Tolectin
<input type="checkbox"/> DayPro	<input type="checkbox"/> Magnaprin	<input type="checkbox"/> Toradol
<input type="checkbox"/> Diflunisal/Dolobid	<input type="checkbox"/> Meclomen	<input type="checkbox"/> Trilisate

**Tylenol and Extra Strength Tylenol are the medication of choice for pain management for people with Kidney problems.**

<b>MEDICAL HISTORY</b> <b>RENAL (KIDNEY)-HYPERTENSION-DIABETES</b>
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Do you have a history of kidney disease?  No  Yes (check all that apply from below list)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name	Date Diagnosed	Name	Date Diagnosed
<input type="checkbox"/> Acute Renal Failure		<input type="checkbox"/> Kidney Cyst(s)	
<input type="checkbox"/> Anemia - Chronic		<input type="checkbox"/> Lupus Nephritis	
<input type="checkbox"/> Anemia – Iron Deficient		<input type="checkbox"/> Membranous Nephropathy	
<input type="checkbox"/> Chronic Kidney Disease		<input type="checkbox"/> Nephrolithiasis	
<input type="checkbox"/> End-Stage Kidney Disease		<input type="checkbox"/> Nephrotic Syndrome	
<input type="checkbox"/> Glomerulonephritis		<input type="checkbox"/> Polycystic Kidney Disease	
<input type="checkbox"/> Hypertension/High Blood Pressure		<input type="checkbox"/> Proteinuria	
<input type="checkbox"/> IgA Nephropathy		<input type="checkbox"/> Renal Tumor	
<input type="checkbox"/> Interstitial Nephritis			
<b>ENDOCRINE</b>			
<input type="checkbox"/> Adrenal Gland Tumor		<input type="checkbox"/> Hyperaldosteronism	
<input type="checkbox"/> Diabetes Mellitus, Type 1		<input type="checkbox"/> Hyperparathyroidism	
<input type="checkbox"/> Diabetes Mellitus, Type 2		<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> Diabetic Nephropathy		<input type="checkbox"/> Hypoaldosteronism	
<input type="checkbox"/> Diabetic Peripheral Neuropathy		<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> Diabetic Retinopathy			
<b>ELECTROLYTE IMBALANCE</b>			
<input type="checkbox"/> Hypercalcemia		<input type="checkbox"/> Hypokalemia	
<input type="checkbox"/> Hyperkalemia		<input type="checkbox"/> Hypomagnesemia	
<input type="checkbox"/> Hypermagnesemia		<input type="checkbox"/> Hyponatremia	
<input type="checkbox"/> Hypernatremia		<input type="checkbox"/> Hypophosphatemia	
<input type="checkbox"/> Hyperphosphatemia		<input type="checkbox"/> Metabolic disorder	
<input type="checkbox"/> Hypocalcemia			
<b>HEART</b>			
<input type="checkbox"/> Anticoagulant use		<input type="checkbox"/> Congestive Heart Failure	
<input type="checkbox"/> Arrhythmias		<input type="checkbox"/> Coronary Artery Disease	
<input type="checkbox"/> Bradycardia		<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Cardiomyopathy		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Carotid Artery Stenosis		<input type="checkbox"/> Tachycardia	
<input type="checkbox"/> Congenital Heart Disease		<input type="checkbox"/> Valve Disorder	
<b>VASCULAR</b>			
<input type="checkbox"/> CVA/TIA/Stroke		<input type="checkbox"/> Peripheral Neuropathy	

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>MEDICAL HISTORY (continued from previous page)</b>			
<b>Name</b>	<b>Date Diagnosed</b>	<b>Name</b>	<b>Date Diagnosed</b>
<b>VASCULAR (cont).</b>			
<input type="checkbox"/> DVT/Clotting Disorder		<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Peripheral Artery Disease		<input type="checkbox"/> Venous Insufficiency/Stasis/ Varicose Veins	
<b>PULMONARY/LUNGS</b>			
<input type="checkbox"/> Asthma		<input type="checkbox"/> Sarcoidosis	
<input type="checkbox"/> COPD/Emphysema		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Obstructive Sleep Apnea		<input type="checkbox"/> Valley Fever	
<input type="checkbox"/> Pulmonary Hypertension			
<b>GASTROINTESTINAL</b>			
<input type="checkbox"/> Cirrhosis		<input type="checkbox"/> GERD	
<input type="checkbox"/> Colitis		<input type="checkbox"/> GI Bleed	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Peptic Ulcers	
<b>GENITOURINARY/UROLOGIC</b>			
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Hematuria	
<input type="checkbox"/> Bladder Incontinent		<input type="checkbox"/> Hydronephrosis	
<input type="checkbox"/> Cystitis		<input type="checkbox"/> Recurrent UTI's	
<b>RHEUMATOLOGY</b>			
<input type="checkbox"/> Erythematousus		<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Sjogren's Syndrome	
<input type="checkbox"/> Gout		<input type="checkbox"/> Systemic Lupus	
<input type="checkbox"/> HIV		<input type="checkbox"/> Wegner's Granulomatosis	
<input type="checkbox"/> Rheumatoid Arthritis			
<b>SKELETAL</b>			
<input type="checkbox"/> Degenerative Joint Disease		<input type="checkbox"/> Osteopenia	
<input type="checkbox"/> Kyphosis		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Osteoarthritis		<input type="checkbox"/> Scoliosis	
<b>CANCER</b>			
<input type="checkbox"/> Bladder		<input type="checkbox"/> Pancreatic	
<input type="checkbox"/> Breast		<input type="checkbox"/> Prostate	
<input type="checkbox"/> Colon		<input type="checkbox"/> Renal	
<input type="checkbox"/> Lung		<input type="checkbox"/> Other	
<input type="checkbox"/> Ovarian/Uterus/Cervix			

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>MEDICAL HISTORY (continued from previous page)</b>			
<b>Name</b>	<b>Date Diagnosed</b>	<b>Name</b>	<b>Date Diagnosed</b>
<b>OTHER</b>			
<input type="checkbox"/> Anxiety/Depression		<input type="checkbox"/> NSAID use	
<input type="checkbox"/> Deafness		<input type="checkbox"/> Obesity	
<input type="checkbox"/> Hyperlipidemia		<input type="checkbox"/> Vitamin D Deficiency	
Other:			
<b>SURGICAL HISTORY</b>			
<b>Name</b>	<b>Date of Surgery</b>	<b>Name</b>	<b>Date of Surgery</b>
<input type="checkbox"/> Adrenal Surgery		<input type="checkbox"/> Hemodialysis Catheter	
<input type="checkbox"/> Amputation Type:		<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Any metal in body, where?		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Aortic Valve Repair		<input type="checkbox"/> Kidney Ablation	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Kidney Artery Angioplasty	
<input type="checkbox"/> AV Fistula		<input type="checkbox"/> Kidney Biopsy	
<input type="checkbox"/> AV Graft		<input type="checkbox"/> Lithotripsy	
<input type="checkbox"/> Bladder Surgery, Type:		<input type="checkbox"/> Liver Transplant	
<input type="checkbox"/> Cancer Surgery, Type:		<input type="checkbox"/> Mitral Valve Repair	
<input type="checkbox"/> Carotid Artery Angioplasty		<input type="checkbox"/> Mitral Valve Replacement	
<input type="checkbox"/> Carotid Endarterectomy		<input type="checkbox"/> Nephrectomy: <input type="checkbox"/> left side <input type="checkbox"/> right side	
<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> Orthopedic Surgery	
<input type="checkbox"/> Colon Surgery		<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Coronary Artery Angioplasty/Stent		<input type="checkbox"/> Pancreas Transplant	
<input type="checkbox"/> Cystoscopy		<input type="checkbox"/> Parathyroid Surgery	
<input type="checkbox"/> Eye Surgery		<input type="checkbox"/> Peritoneal Catheter	
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Thyroid Surgery	
<input type="checkbox"/> Heart Bypass Surgery-CABG		<input type="checkbox"/> Ureteral Stent	
<input type="checkbox"/> Heart Transplant		<input type="checkbox"/> Vascular Surgery	
<input type="checkbox"/> Heart/Cardiac Catheterization		Other:	
		<input type="checkbox"/> <b>Renal Transplant:</b> <input type="checkbox"/> Living-related or unrelated <input type="checkbox"/> cadaveric <input type="checkbox"/> left or right side  <u>Facility where transplant was performed:</u>	

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SOCIAL HISTORY						
<b>Smoking Status:</b>						
<input type="checkbox"/> Current, every day smoker: packs smoked per day _____ Year started: _____						
<input type="checkbox"/> Current, some day smoker: packs smoked per day _____ Year started: _____						
<input type="checkbox"/> Former smoker: Year started: _____ Years smoked: _____ Packs smoked per day: _____						
<input type="checkbox"/> Never smoked <input type="checkbox"/> Unknown						
<input type="checkbox"/> Heavy tobacco user: Year started: _____ <input type="checkbox"/> Light tobacco user: Year started: _____						
<b>Alcohol Use:</b>						
<input type="checkbox"/> No history of alcohol use <input type="checkbox"/> Rehabilitation: Year of treatment received for alcohol abuse: _____						
<input type="checkbox"/> Currently consume alcohol (provide quantity and frequency): _____						
<input type="checkbox"/> Former Drinker: Sober since: _____ Previous quantity and frequency: _____						
<input type="checkbox"/> Recovering alcoholic: Sober since: _____ Previous quantity and frequency: _____						
<b>Illicit Drug Use:</b>						
<input type="checkbox"/> No history of illicit drug use <input type="checkbox"/> Rehabilitation: Year of treatment received for drug abuse: _____						
<input type="checkbox"/> Current use: Type of drug: _____, frequency: _____ Dates/Years of use: _____						
<input type="checkbox"/> Previous use: Type of drug: _____, frequency: _____ Dates/Years of use: _____						
Claustrophobic: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Education: <input type="checkbox"/> less than 8th grade <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> post graduate						
Employment status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled Employer: _____						
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner						
FAMILY HISTORY						
Adopted, Family History Unknown <input type="checkbox"/>						
	Living	Deceased	Age at Death	Cause of Death		
Father	<input type="checkbox"/>	<input type="checkbox"/>				
Mother	<input type="checkbox"/>	<input type="checkbox"/>				
Please indicate if a family member has/had any of the following:						
	Father	Mother	Brother	Sister	Children	Other (identify)
Diabetes, Type I:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Type II:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis (identify cause):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>