RENAL ASSOCIATES
of West Michigan, P.C.

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	☐ African American ☐ Asian ☐ American Indian or Alaska Native ☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Decline to Answer
ETHNICITY	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ 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?

☐ No ☐ Yes, please identify reaction:

FOOD ALLERGIES
Please list the foods with the specific allergy or reaction that you have experienced.

FOOD	**ALLERGY or REACTION**

Patient Name: _____ DOB: _____

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

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

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

MEDICAL HISTORY

RENAL (KIDNEY)-HYPERTENSION-DIABETES

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

Patient Name: _____ DOB: _____

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

Patient Name: _____ DOB: _____

MEDICAL HISTORY (continued from previous page)			
Name	**Date Diagnosed**	**Name**	**Date Diagnosed**
OTHER			
☐ Anxiety/Depression		☐ NSAID use	
☐ Deafness		☐ Obesity	
☐ Hyperlipidemia		☐ Vitamin D Deficiency	
Other:			

SURGICAL HISTORY			
Name	**Date of Surgery**	**Name**	**Date of Surgery**
☐ Adrenal Surgery		☐ Hemodialysis Catheter	
☐ Amputation Type:		☐ Hernia Repair	
☐ Any metal in body, where?		☐ Hysterectomy	
☐ Aortic Valve Repair		☐ Kidney Ablation	
☐ Appendectomy		☐ Kidney Artery Angioplasty	
☐ AV Fistula		☐ Kidney Biopsy	
☐ AV Graft		☐ Lithotripsy	
☐ Bladder Surgery, Type:		☐ Liver Transplant	
☐ Cancer Surgery, Type:		☐ Mitral Valve Repair	
☐ Carotid Artery Angioplasty		☐ Mitral Valve Replacement	
☐ Carotid Endarterectomy		☐ Nephrectomy: ☐ left side ☐ right side	
☐ Cholecystectomy		☐ Orthopedic Surgery	
☐ Colon Surgery		☐ Pacemaker	
☐ Coronary Artery Angioplasty/Stent		☐ Pancreas Transplant	
☐ Cystoscopy		☐ Parathyroid Surgery	
☐ Eye Surgery		☐ Peritoneal Catheter	
☐ Gastric Bypass		☐ Thyroid Surgery	
☐ Heart Bypass Surgery-CABG		☐ Ureteral Stent	
☐ Heart Transplant		☐ Vascular Surgery	
☐ Heart/Cardiac Catheterization		Other:	
		☐ **Renal Transplant:** ☐ Living-related or unrelated ☐ cadaveric ☐ left or right side <u>Facility where transplant was performed:</u>	

Patient Name: _____ DOB: _____

SOCIAL HISTORY

Smoking Status:

☐ Current, every day smoker: packs smoked per day _____ Year started: _____

☐ Current, some day smoker: packs smoked per day _____ Year started: _____

☐ Former smoker: Year started: _____ Years smoked: _____ Packs smoked per day: _____

☐ Never smoked ☐ Unknown

☐ Heavy tobacco user: Year started: _____ ☐ Light tobacco user: Year started: _____

Alcohol Use:

☐ No history of alcohol use ☐ Rehabilitation: Year of treatment received for alcohol abuse: _____

☐ Currently consume alcohol (provide quantity and frequency): _____

☐ Former Drinker: Sober since: _____ Previous quantity and frequency: _____

☐ Recovering alcoholic: Sober since: _____ Previous quantity and frequency: _____

Illicit Drug Use:

☐ No history of illicit drug use ☐ Rehabilitation: Year of treatment received for drug abuse: _____

☐ Current use: Type of drug: _____, frequency: _____ Dates/Years of use: _____

☐ Previous use: Type of drug: _____, frequency: _____ Dates/Years of use: _____

Claustrophobic: ☐ Yes ☐ No

Education: ☐ less than 8th grade ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 2 year college ☐ 4 year college ☐ post graduate

Employment status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Employer: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

FAMILY HISTORY

Adopted, Family History Unknown ☐

	Living	Deceased	Age at Death	Cause of Death
Father	☐	☐		
Mother	☐	☐		

Please indicate if a family member has/had any of the following:

	Father	Mother	Brother	Sister	Children	Other (identify)
Diabetes, Type I:	☐	☐	☐	☐	☐	☐
Diabetes, Type II:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Heart Disease (identify type):	☐	☐	☐	☐	☐	☐
Kidney Disease (identify type):	☐	☐	☐	☐	☐	☐
Kidney Failure	☐	☐	☐	☐	☐	☐
Dialysis (identify cause):	☐	☐	☐	☐	☐	☐
Cancer (identify type):	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐