NEPHROLOGY CONSULTANTS
OF NORTHWEST OHIO

NEW PATIENT INTAKE AND HISTORY FORM
(Please print)

Today's Date: _____

Name: _____ **Date of Birth:** _____

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____
(Name/City/Phone #)

Are you currently under the care of any other Specialists (Cardiologist, Urologist, etc.)? Yes No
If you answered "Yes", please give your Specialist's name and their specialty: _____
_____
_____
_____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____
Timing/Onset: When did symptoms first occur? _____
Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____
_____
Modifying Factors: What makes the condition better and/or worse? _____

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ Acute renal failure syndrome	___ Chronic kidney disease	___ Heart attack	___ Retinopathy
___ Anemia	___ Congestive heart failure	___ HIV	___ Seizures
___ Anxiety	___ COPD	___ Hypertension, essential	___ SLE (Lupus)
___ Arthritis	___ Coronary artery bypass	___ Kidney stones	___ Sleep apnea
___ Asthma	___ Depression	___ Liver disease (Cirrhosis)	___ Stroke
___ Blood clot (Embolism)	___ Diabetes – Type 1	___ Liver disease	___ Urine retention
___ Blood in urine (Hematuria)	___ Diabetes – Type 2	___ Neuropathy	___ UTI
___ BPH	___ Emphysema	___ Renal cyst	___ Viral hepatitis
___ Cancer: _____	___ Gout	___ Renal transplant recipient	

___ Other: _____
_____

PAST SURGICAL HISTORY:

Please list any procedure you have had in the past. Then write the year, reason, and hospital on the line to the right of it.

None

___ Prostatectomy; Transurethral
___ Lithotripsy
___ Nephrolithotomy, Removal of Calculi
___ Arteriovenostomy for Renal Dialysis
___ Nephrectomy
___ Nephrectomy; Partial
___ Transplantation; Renal
___ Adrenalectomy; Partial
___ Adrenalectomy; Total

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Please describe your current tobacco use:

Smoker, current status unknown | Light tobacco smoker | Heavy tobacco smoker | Current every day smoker
Current some day smoker | Former smoker | Never smoker | Unknown if ever smoked

If you have used any type of tobacco products, please list each below followed by the number of years and how much per day: _____

_____

Do you drink alcoholic beverages? Yes No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? Yes No

If yes, please indicate what type of drug and how often: _____

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

	Mother	**Father**	**Sister**	**Brother**	**Daughter**	**Son**
Autoimmune dis. or Lupus	_____	_____	_____	_____	_____	_____
Chronic kidney disease	_____	_____	_____	_____	_____	_____
Coronary artery disease	_____	_____	_____	_____	_____	_____
Diabetes mellitus	_____	_____	_____	_____	_____	_____
Dialysis	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____

Other: _____

ALLERGY HISTORY:

No Known Allergies **NKDA (No Known Drug Allergies)**

___ ACE Inhibitors
___ Cephalosporins
___ Cipro
___ Iodinated Contrast Media
___ Latex
___ Penicillin
___ Sulfa Drugs

Other: _____

_____

_____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. Your doctor will discuss any positive responses with you.

General: **Normal**
- ❑ Altered Taste
- ❑ Appetite Loss
- ❑ Chills
- ❑ Fatigue
- ❑ Fever

Skin: **Normal**
- ❑ Rash

HEENT: **Normal**
- ❑ Blurred Vision
- ❑ Vertigo
- ❑ Nasal Congestion
- ❑ Sore Throat

Respiratory: **Normal**
- ❑ Cough
- ❑ Coughing up Blood
- ❑ Difficulty Breathing

Cardiovascular: **Normal**
- ❑ Chest Pain
- ❑ Edema
- ❑ Leg Cramps
- ❑ Palpitations

Gastrointestinal: **Normal**
- ❑ Abdominal Pain
- ❑ Black Tarry Stool
- ❑ Blood in Stool
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

Genitourinary: **Normal**
- ❑ Blood in Urine
- ❑ Hesitancy
- ❑ Incontinence
- ❑ Painful Urination
- ❑ Excessive Urination at Night

Musculoskeletal: **Normal**
- ❑ Back Pain
- ❑ Joint Pain

Neurological: **Normal**
- ❑ Dizziness/Lightheaded
- ❑ Headaches
- ❑ Loss of Consciousness
- ❑ Numbness
- ❑ Tremors
- ❑ Weakness in Extremities

Psychiatric: **Normal**
- ❑ Anxiety
- ❑ Depression

Endocrine/Glands: **Normal**
- ❑ Excessive Urination

Hematology: **Normal**
- ❑ Easy Bruising