KHC
The Kidney and Hypertension Center

Thank you for making your nephrology consultation appointment with our office, you have an appointment on _____ at _____ ☐ am / ☐ pm at the above office location. Please fill out the following information to the best of your ability to help us with your registration process. Please bring this paperwork to your appointment along with your insurance cards, photo ID and medication list (to include name, strength and how often you take it).

Name: _____ Sex: ☐ M ☐ F Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Referring Physician: _____ Primary Physician: _____

Allergies: _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco Use: ☐ None ☐ Previous User ☐ Current User _____ pack(s)/day _____ # of years

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Chew ☐ Snuff

Alcohol Use: ☐ None ☐ Yes _____number of drinks per week

Drug Use: Any recreational drug use? ☐ None ☐ Previous User ☐ Yes _____

Caffeine Intake: ☐ None ☐ Coffee ☐ Tea ☐ Soda _____number of cups/cans per day

Diet: Any specific diet? ☐ Diabetic Diet ☐ Calorie Restricted ☐ Low Fat ☐ Low Sodium ☐ Low Potassium ☐ Low Sugar ☐ Vegetarian ☐ Other: _____

Exercise: Any regular exercise? ☐ No ☐ Yes: What type? _____

Family History:

Patient's Father:

☐ Living: Illnesses: _____
☐ Deceased: Cause: _____
☐ Health Status Unknown

Patient's Mother:

☐ Living: Illnesses: _____
☐ Deceased: Cause: _____
☐ Health Status Unknown

Does Any Person, Blood Related, Have Any Of The Following:

Illness		Relation
Hypertension	☐ Y ☐ N	
Kidney Disease	☐ Y ☐ N	
Kidney Stones	☐ Y ☐ N	
Stroke	☐ Y ☐ N	
Heart Attack	☐ Y ☐ N	
Blood/Protein in Urine	☐ Y ☐ N	
Heart Disease	☐ Y ☐ N	
Thyroid Problems	☐ Y ☐ N	
High Cholesterol	☐ Y ☐ N	

Illness		Relation
Congestive Heart Failure	☐ Y ☐ N	
Urinary Problems	☐ Y ☐ N	
Glaucoma	☐ Y ☐ N	
Diabetes	☐ Y ☐ N	
ESRD/Dialysis	☐ Y ☐ N	
Cancer Type:	☐ Y ☐ N	
Other:	☐ Y ☐ N	

Children: _____ Siblings: _____

Healthy? List any illnesses: _____

Are you experiencing any of the following symptoms? (check those that apply):

General:

☐ Decreased energy level
☐ Decreased appetite
☐ Weight gain
☐ Weight loss

Eyes/Ears:

☐ Vision changes
☐ Hearing loss

Respiratory:

☐ Blood in sputum
☐ Cough

Skin:

☐ Burning
☐ Rash

Genitourinary:

☐ Painful urination
☐ Blood in urine
☐ Nighttime urination
☐ Urgency

Cardiovascular:

☐ Chest pain
☐ Palpitations

Musculoskeletal:

☐ Joint pain
☐ Swelling

Neurological:

☐ Dizziness
☐ Seizures

Gastrointestinal:

☐ Abdominal pain
☐ Vomiting
☐ Nausea

Endocrinology:

☐ Temperature intolerance
☐ Frequent urination

Blood/Lymphatic:

☐ Easy bruising
☐ Anemia

Medications:

It is very important for us to have the most accurate medication information possible. Please include all prescriptions, non-prescriptions, vitamins, home remedies, birth control, herbs, etc.

Medication	Dose (e.g.mg/pill)	Times Per Day