

NEPHROLOGY ASSOCIATES OF SYRACUSE, P.C.

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PATIENT HEALTH INFORMATION:

Name: _____ **Age:** _____ **DOB:** _____

Address: _____

Home Phone: _____ **Work Phone:** _____

Referring Physician: _____ **Marital Status:** M S Divorced

Place of Employment: _____ **Occupation:** _____

Next of Kin: _____ **Phone #:** _____

Allergies to foods/medications: PLEASE LIST: _____



Current Medications: (including all over the counter medications, pain medications, vitamins or supplements)

| Name of Drug: | Why are you taking it?: | Dosage: | How often?: |
|----------------------|--------------------------------|----------------|--------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please tell us the nature of your problem which resulted in you coming to our office:

Medical History: Please list all past and current medical conditions: (IE. Hypertension, angina, diabetes, etc.) _____

List all previous surgeries: _____

When and where did you last have blood test?

When: _____ **Where:** _____

When and where did you last have x-rays?

When: _____ **Where:** _____

Have you ever had x-rays, ultrasounds or other special kidney tests:

When: _____ **Where:** _____

Social History:

Do you smoke? YES NO If yes, how many packs per day?: _____

Do you use alcohol? YES NO If yes, how much per week?: _____

Have you ever used recreational drugs? YES NO

Please list all previous hospitalizations, where at and why: _____

List all physicians you see and where you see them:

Primary Care Physician:

Address:

Other Physicians:

Address:

Family History:

Please circle any of the following diseases present within your family and list who they are associated with:

| Disease: | Present in which family member: | Age of Onset: (if known) |
|----------------------------|--|---------------------------------|
| Diabetes | _____ | _____ |
| Dialysis | _____ | _____ |
| Kidney Transplant | _____ | _____ |
| High Blood Pressure | _____ | _____ |
| Kidney Stones | _____ | _____ |
| Heart Disease | _____ | _____ |
| Stroke | _____ | _____ |
| Kidney Disease | _____ | _____ |
| Tuberculosis | _____ | _____ |
| Cancer | _____ | _____ |
| Other | _____ | _____ |

Please answer the following questions by circling the appropriate answer:

YES NO Do you cook with salt or add salt to food?

YES NO Have you ever been instructed in a special diet?

YES NO Do you have impotence or other sexual problems?

YES NO Have you ever had a blood transfusion?

YES NO Has any family member had problems similar to yours?

**Have you experienced any of the following changes in the previous 12 months:
Please circle and give details:**

- Headaches/Dizziness:** _____
- Visual Difficulties:** _____
- Hearing Difficulties:** _____
- Swallowing Difficulties:** _____
- Cough:** _____
- Shortness of Breath:** _____
- Vomiting Blood:** _____
- Nausea or Vomiting:** _____
- Chest Pain:** _____
- Abdominal Pain or Ulcers:** _____
- Heart Condition:** _____
- Blackness in Stools:** _____
- Blood in Stool:** _____
- Diarrhea or Constipation:** _____
- Change in Bowel Habits:** _____
- Burning or Pain with Urination:** _____
- Hesitancy or Dribbling Urine:** _____
- Blood in Urine:** _____
- Foamy Urine:** _____
- Significant Back Pain:** _____
- Joint Stiffness or Pain:** _____
- Joint Swelling or Pain:** _____
- Skin Rashes-Where?:** _____
- Numbness in Arms or Legs:** _____
- Weakness in Arms or Legs:** _____
- Swelling in Legs or Feet:** _____
- Pain in Legs when Walking:** _____
- Muscle Cramps:** _____
- Fevers or Chills:** _____
- Lymph Node Swelling:** _____
- Intolerance to Heat or Cold:** _____
- Anxiety or Depression:** _____
- Seizures or Fainting:** _____
- Tiredness or Fatigue:** _____
- Weight Change:** _____
- Difficulty Sleeping:** _____

Please Write Down Any Issues You Would Like to Discuss with the Physician:

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(315) 478-3311**

**SYRACUSE, NY 13212
(315) 476-5211**