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KIDNEY CARE CENTER OF GEORGIA

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PLEASE PRINT ON FORM Account #:_____ **PLEASE USE BLACK INK**

Nephrology New Patient Questionnaire

Patient Name: _____ **Date of Birth: _____/_____/_____**
Primary Care Physician:_____ **Telephone: _____-_____-_____**
Pharmacy:_____ **Pharmacy Phone: _____-_____-_____**
Pharmacy Address:_____ State: _____ Zip: _____

Medical History

Please Check Any of the Following Conditions that you are currently being treated for or have had within the past 10 years.

❑ High Blood Pressure	❑ Congestive Heart Failure	❑ Bleeding from Digestive Tract	❑ Thyroid Disease
❑ Diabetes	❑ High Cholesterol	❑ Liver Disease	❑ Gout
❑ Eye Problems from Diabetes	❑ Heartburn (Acid Reflux)	❑ Hepatitis B or C	❑ Migraine Headaches
❑ Heart Attack	❑ Emphysema	❑ Enlarged Prostate	❑ Seizures
❑ Stents in Heart	❑ Chronic Bronchitis	❑ Blood Clots	❑ Cancer*
❑ Pacemaker	❑ Stroke	❑ Arthritis	*List Types Below

List Cancer Types and any other Medical Conditions you may have had in the past:_____
_____
_____

List Any Surgeries you have had and the year it was performed:_____
_____
_____

Family History

Check the below disease if your Parents, Siblings, or Children have or have had any of the following conditions:

Medical Condition	Father	Mother	Siblings	Children	None
Kidney Disease	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Gout	❑	❑	❑	❑	❑
ADPKD	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑

Immunization History

Have you had these Vaccinations?

❑ **Flu Vaccine *Within the Past Year***

❑ **Pneumonia Vaccine *Within the Past 5 Years***

Are you currently or have you ever taken any of the following Medications on a Daily/Weekly Basis?

Please Check which ones:

❑ **Advil / Ibuprofen**
❑ **Celebrex**
❑ **Motrin**
❑ **Aleve**
❑ **Diclofenac**
❑ **Naproxen / Naprosyn**
❑ **BC Tablets/Powder**
❑ **Goody's Powders**
❑ **Vioxx**
❑ **Bextra**
❑ **Mobic**
❑ **Voltaren**

Review of Symptoms Related to you Kidneys

Check any of these Kidney Related Symptoms that you are Currently experiencing:

❑ **Swelling in Hands / Legs / Feet**	❑ **Difficulty Starting Urine Stream**	❑ **Shortness Of Breath**
❑ **Frequent Urination**	❑ **Incomplete Bladder Emptying**	❑ **Cough / Wheezing**
❑ **Painful Urination**	❑ **Nose Bleeds**	❑ **Headache / Dizziness**

Personal History

Check all that Apply to You:

Tobacco Use (Smoke/Chew)	❑ **Former** When did you Quit? _____	❑ **Current** How often?_____	❑ **Never**
Alcohol Use	❑ **Former**	❑ **Currently** Rarely / 1-2 Drinks per Day / 3 or more Drinks per Day	❑ **Never**
Recreational Drug Use	❑ **Former**	❑ **Current**	❑ **Never**

Allergies

Please List any Allergies to Medications that you have and what Symptoms you had.

Medication	Symptoms

List any Additional Medications and reactions below if needed: _____

_____

_____

_____

Medications

Please List the Medications you are Currently Taking Below:

Medication (Example: *Hydralazine*)	**Dosage** (Example: *25mg*)	**Frequency** (Example: *Take 1 Tablet 3 Times a Day*)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

***If your medications exceed this page please bring medications to your apt or bring a typed listed to your appointment.**