SAN ANTONIO KIDNEY

REGISTRATION FORM

PATIENT INFORMATION			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Contact Preference ☐ Home Phone ☐ Work Phone ☐ Cell Phone	May we leave you a message regarding medical care & test results? ☐ Yes ☐ No		
Email	Social Security No	Gender Male ☐ Female ☐	
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander ☐ More than one	Ethnicity ☐Hispanic/Latin Descent ☐Not Hispanic/Latin Descent	
Primary Care Physician	Referring Physician		
Reason for your visit today			
Other physicians involved in your care			
Pharmacy Name	Pharmacy Address/Crossroads	Pharmacy Phone ( )	
Occupation	Employer		
Emergency Contact	Emergency Contact Phone ( )	Relationship	

RELEASE OF MEDICAL INFORMATION	☐ **Do not release my information to anyone**	
Name	Phone ( )	Relationship
Name	Phone ( )	Relationship

INSURANCE INFORMATION		
Primary Insurance Company	Insurance Company Address	
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Employer
Identification Number	Group/Policy Number	
Secondary Insurance Company	Insurance Company Address	
Policy Holder Name	Policy Holder Date of Birth	Policy Holder Employer
Identification Number	Group/Policy Number	

PAST MEDICAL HISTORY (Check all that apply; fill in dates where appropriate)

Kidneys/Bladder/Prostate

☐ Frequent Urinary Tract Infections (>2-3/year)
☐ Episodes of Pyelonephritis (Kidney Infection)
☐ Kidney Stones
☐ Enlarged Prostate
☐ History of Acute Kidney Failure, Date: _____
☐ Blood in the Urine, Date: _____
☐ Protein in the Urine, Date: _____
☐ Incontinence
☐ Overactive Bladder
☐ Kidney Cysts/Polycystic Kidneys

Head, Ears, Nose, Throat

☐ Hearing Loss
☐ Vision Loss
☐ Glaucoma
☐ Cataracts
☐ Macular Degeneration
☐ Excessive Dry Eyes
☐ Nose Bleeds
☐ Nasal Allergies/Congestion
☐ Headaches
☐ Head Trauma

Cardiovascular

☐ Hypertension, Year of Diagnosis: _____
☐ Coronary Artery Disease
☐ Myocardial Infarction (Heart Attack), Date: _____
☐ Congestive Heart Failure
☐ Atrial Fibrillation
☐ Ventricular Arrhythmias
☐ Pacemaker/Defibrillator Placement
☐ Peripheral Vascular Disease (poor circulation to legs)
☐ Valve Disease:
☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Pulmonary
☐ Edema (Swelling)
☐ Aneurysm

Lungs

☐ Emphysema/Bronchitis/COPD
☐ Asthma
☐ Tuberculosis
☐ Pulmonary Hypertension

Endocrine and Glandular Disorders

☐ Diabetes Mellitus, Type: I ☐ II ☐
Year of Diagnosis: _____
☐ Underactive Thyroid ☐ Overactive Thyroid
☐ High Cholesterol
☐ Obesity

Gastrointestinal

☐ Stomach Ulcer
☐ Acid Reflux/Heartburn
☐ Diverticulosis/Diverticulitis
☐ GI Bleeding
☐ Liver Disease/Cirrhosis
☐ Hepatitis A ☐ B ☐ C ☐ /Jaundice
☐ Pancreatitis
☐ Colon Polyps
☐ Hemorrhoids

Blood and Oncology

☐ Cancer/Tumor, Location: _____
Date: _____
Chemotherapy? Yes☐ No☐, Radiation? Yes☐ No☐
☐ Blood Clots
☐ Anemia
☐ Blood Transfusion
☐ Bleeding Disorder
☐ Thrombocytopenia
☐ Leukemia/Lymphoma

Musculoskeletal Disorders

☐ Arthritis: ☐ Osteoarthritis ☐ Rheumatoid
☐ Lupus
☐ Gout
☐ Low Back Pain
☐ Osteoporosis
☐ Use of Non-Steroidal Anti-Inflammatories (NSAID)

Skin Disorders

☐ Psoriasis
☐ Dry Skin
☐ Skin Ulcers

Neurologic/Psychiatric

☐ Seizures
☐ Strokes
☐ TIA (Mini-Strokes)
☐ Migraines
☐ Tremor
☐ Neuropathy
☐ Vertigo
☐ Depression
☐ Anxiety or Panic Attacks
☐ Bipolar Disorder
☐ Excessive Alcohol Use/Alcoholism
☐ Illegal Drug Use

PAST SURGICAL HISTORY (Check all that apply and provide dates where possible)

☐ Cholecystectomy (Gall Bladder Removal)
☐ Appendectomy
☐ Tonsillectomy/Adenoidectomy
☐ Reduction of Fracture
☐ Hysterectomy
☐ Mastectomy Left ☐ Right ☐
☐ Cataract Extraction Left ☐ Right ☐
☐ Other (list type and date) _____

☐ Coronary Artery Bypass:
Vessel 1☐ 2☐ 3☐ 4☐ 5☐ 6☐
☐ Leg Bypass Left ☐ Right ☐
☐ Colectomy Partial ☐ Total ☐
☐ Hernia Repair:
Inguinal ☐ Left ☐ Right☐; Incisional ☐, Ventral ☐

_____

_____

ALLERGIES TO MEDICATIONS

Name of Medication (ex: Codeine)	Description of Reaction or Accompanying Symptoms

MEDICATION LIST

Please list all current prescription and over-the-counter (OTC) medications you are currently taking or attach a copy of your current list of medications. Include hormones, birth control pills, vitamins, supplements, calcium, and special dietary aides. Also include medications that have been discontinued in the last 3 months and the date is was discontinued.

Medication Name	**Dosage**	**Frequency**	**Prescribing Doctor**
(e.g. Lisinopril)	(e.g. 40 mg, 20 units)	(e.g. 1 tablet twice a day)	(e.g. Dr. Smith)

FAMILY HISTORY

Relative	Living	Age or Age of Death	List Illnesses and/or cause of death
Mother	Y☐ N☐		
Father	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		
# Brother ☐ Sister ☐ Child ☐	Y☐ N☐		

SOCIAL HISTORY

Current Occupation: _____

Employer: _____ Hours worked each week: _____

Previous Occupation: _____

Are you disabled? Yes☐ No☐ If so, date and why: _____

Highest Level of Education Completed: _____

Marital Status: Married☐ Single☐ Divorced☐ Widowed☐

Who do you live with? _____

Do you drink alcohol? Yes☐ No☐ If yes, what do you drink? Beer☐ Wine☐ Liquor☐,
How many drinks in average week? _____

Have you quit drinking? Yes☐ No☐ If so, when did you quit? _____ How many drinks in average week? _____

Do you smoke? Yes☐ No☐ If yes, how many packs/day? _____

Have you quit smoking? Yes☐ No☐ If yes, how many packs/day? _____ Age started: _____Age quit: _____

Do you or did you ever smoke cigars, pipes, or chew tobacco? Yes☐ No☐

Do you or did you ever use street drugs (Cocaine, Marijuana, LSD, Speed, IV Drugs, etc.)? Yes☐ No☐

Do you drink coffee or caffeinated sodas frequently (< 2 per day)? Yes☐ No☐ If yes, how much each day? _____

HEALTH MAINTENANCE

☐ Colonoscopy, Date: _____ ☐ Mammogram, Date: _____

☐ Flu Vaccine, Date: _____ ☐ Pneumonia Vaccine, Date: _____

REVIEW OF SYMPTOMS (check all that apply, clarify below if needed)

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight gain/loss (> 10 lbs.)
- ☐ Recent Hospitalization
- ☐ Recent Illness
- ☐ Poor Appetite

Skin
- ☐Rashes
- ☐Excessive Itching
- ☐Ulcers on Skin
- ☐Skin Color Changes
- ☐Excessive Sweating

Head, Eyes, Ears, Nose, Throat
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Sudden Change in Vision
- ☐ Excessively Dry Eyes
- ☐ Frequent Bloody Nose
- ☐ Recurrent Nasal Congestion
- ☐ Ulcers in mouth/lips
- ☐ Dry Mouth

Neck
- ☐Neck Mass
- ☐Neck Swelling
- ☐Swollen Glands

Lungs
- ☐Shortness of Breath
- ☐Wheezing
- ☐Chronic Cough
- ☐Bloody Sputum

Heart
- ☐Chest Pain
- ☐Swelling of Feet
- ☐Irregular Heart Beat
- ☐Cramps in Legs with Walking
- ☐Heart Murmurs
- ☐Fainting or Passing Out
- ☐High Blood Pressure
- ☐Excessively Low Blood Pressure
- ☐Heart Stent
- ☐Pacemaker
- ☐Wake up at Night Short of Breath
- ☐Short of Breath Lying Flat in Bed

Stomach/Intestines
- ☐Abdominal Pain
- ☐Blood in Stool
- ☐Black Tarry Stools
- ☐Nausea &/or Vomiting
- ☐Diarrhea
- ☐Frequent Heartburn
- ☐Jaundice
- ☐Polyps

Kidneys/Bladder
- ☐ Blood in the Urine
- ☐ Urgency or Overactive Bladder
- ☐ Burning or Pain with Urination
- ☐ Urinate frequently (more than usual)
- ☐ Flank Pain
- ☐ Hesitancy or incomplete emptying
- ☐ Incontinence
- ☐ Excessive Urination at Night
- ☐ Foamy Urine

Men
- ☐Problems with Erections
- ☐Weak or Slow Urinary System

Women
- ☐Lump or Mass in Breast
- ☐Nipple Discharge
- ☐Excessive Menstrual Bleeding

Muscles/Joints/Bones
- ☐Frequent Gout Attacks
- ☐Joint Pain
- ☐Joint Stiffness
- ☐Joint Swelling
- ☐Muscle Pain
- ☐Muscle Weakness

Nerves/Brain
- ☐Numbness or Tingling
- ☐Dizziness or Vertigo
- ☐Seizures
- ☐Tremors or Shaking
- ☐Memory Loss
- ☐Balance Problems/Falls

Psychiatric
- ☐Depression
- ☐Anxiety
- ☐Insomnia/Trouble Sleeping

Endocrine/Glands
- ☐ Thyroid Problems
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive Thirst

Blood/Lymph Nodes
- ☐Anemia/Low Blood Count
- ☐Easy Bruising
- ☐Easy Bleeding
- ☐Enlarged Lymph Nodes

Explanation: _____