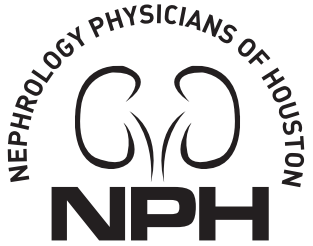

NEPHROLOGY • DIALYSIS • HYPERTENSION • TRANSPLANTATION

(Certified Diplomate of the American Board of Internal Medicine and Nephrology)

(**Board Certified Specialist in Hypertension)

Rafael C. Esquenazi, MD**, FACP, FASN
Mary A. Washington, MD, FACP
Ather R. Khokhar, MD

NEW PATIENT/ UPDATED MEDICAL INFORMATION

Today's Date ____/____/____

Last _____ First _____ Initial _____ Male ☐ Female ☐

SS# ____/____/____ Birthdate ____/____/____ Age _____

Date of last physical examination _____

What is the reason for today's visit? _____

MEDICATIONS

List all medications & dosage you are currently taking.
Include prescription, OTC, & herbal.

_____

_____

_____

_____

_____

_____

_____

_____

Are there any medications which you stopped taking in the past month?

Yes ☐ No ☐

If yes, list _____

Are you currently taking Aspirin, Advil or Motrin?

Yes ☐ No ☐

If yes, how often? _____

ALLERGIES

List any allergies to medications.

_____

_____

_____

_____

_____

_____

_____

List all environmental & food allergies.
Describe your reactions to each.

Allergies	Reaction

FAMILY HISTORY

Check any condition(s) associated with your family history and list the relationship.

- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Chemical Dependency _____
- ☐ Diabetes _____
- ☐ Gout _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Hypertension _____
- ☐ Kidney Cancer _____
- ☐ Kidney Disease _____
- ☐ Kidney Stones _____
- ☐ Liver Disease _____
- ☐ Obesity _____
- ☐ Prostate Cancer _____
- ☐ Stroke _____
- ☐ Other: _____

HOSPITALIZATIONS

Year	Surgeries	Reason for Hospitalization & Outcome
Year	Serious Illness/Injuries	Outcome

Have you ever had a blood transfusion? Yes ☐ No ☐

If yes, please give approximate dates _____

IMMUNIZATION HISTORY

- Tetanus _____ Date _____
- Hepatitis A _____ Date _____
- Hepatitis B _____ Date _____
- Pneumovax _____ Date _____
- Pneumoccoal _____ Date _____

HEALTH HABITS

Please check the areas that apply. If yes, please indicate frequency.

- Smoke ☐ Yes ☐ No _____
- Tobacco ☐ Yes ☐ No _____
- Alcohol ☐ Yes ☐ No _____
- Drugs ☐ Yes ☐ No _____
- Caffeine ☐ Yes ☐ No _____
- Exercise ☐ Yes ☐ No _____

CONDITIONS

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Infection
- ☐ Bleeding Disorders
- ☐ Bowl Obstruction
- ☐ Bulimia
- ☐ Cancer of _____
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis _____
- ☐ Hernia of _____
- ☐ Herpes
- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker/Defibrillator
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric care
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

SYMPTOMS

GENERAL

- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Heat/cold intolerance
- ☐ Loss of consciousness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Swollen glands
- ☐ Weight gain
- ☐ Weight loss

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thrist
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Loss of balance
- ☐ Nosebleeds
- ☐ Pain
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Room spins
- ☐ Sinus problems
- ☐ Swelling of extremities
- ☐ Vertigo
- ☐ Vision-Flashes
- ☐ Vision-Halos

RESPIRATORY

- ☐ Coughing blood
- ☐ Difficulty breathing with exertion
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ Wheezing

MUSCLE/JOINT/BONE

Pain, swelling, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITOURINARY

- ☐ Blood in urine
- ☐ Burning
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Nighttime urination
- ☐ Painful urination
- ☐ Penile discharge

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Changes in hearing
- ☐ Difficulty swallowing/chewing
- ☐ Double vision
- ☐ Dry eye
- ☐ Glasses/contacts
- ☐ Hay fever

SINUS PROBLEMS

- ☐ Sinus headaches
- ☐ Sinus infections
- ☐ Sinus pressure

SKIN

- ☐ Burning
- ☐ Jaundice
- ☐ Lesions
- ☐ Rash
- ☐ Sores

ADDITIONAL CONDITIONS

- ☐ Blood clots
- ☐ Breast lumps or discharge
- ☐ Poor circulation of legs
- ☐ Thrombophlebitis
- ☐ Recent fractures: _____

OCCUPATIONAL

☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Check if your work exposes you to the following:

☐ Stress ☐ Heavy Lifting ☐ Hazardous Substances ☐ Other _____

Occupation: _____

PATIENT AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

Reviewed By _____ Date _____