PATIENT INFORMATION: (PLEASE PRINT)

LAST NAME _____ FIRST NAME_____ MI _____

SEX: ☐ MALE ☐ FEMALE BIRTH DATE _____/ _____/ _____

ADDRESS:_____ APT. #: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY _____

HOME PHONE: (_____) _____-_____ SOCIAL SECURITY: _____-_____-_____

CELL PHONE: (_____) _____-_____ EMAIL ADDRESS: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO SPECIFY

PRIMARY RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ AMERICAN-INDIAN OR ALASKAN NATIVE

☐ ASIAN ☐ DECLINE TO SPECIFY ☐ UNKNOWN ☐ OTHER_____

ENGLISH PROFICIENCY: ☐ WELL ☐ NOT WELL PREFERRED LANGUAGE:_____

EMPLOYER: _____ WORK PHONE: (_____) _____-_____

EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED OCCUPATION _____

INSURANCE / PAYMENT INFORMATION: *(Circle one):* INSURANCE CASH CHECK

PRIMARY INSURANCE:

PLAN NAME: _____NAME OF INSURED: _____ DOB_____

GROUP #: _____ MEMBER ID / POLICY # _____

INSURED'S RELATIONSHIP TO PATIENT _____ PHONE # (_____) _____-_____

SECONDARY

PLAN NAME: _____ NAME OF INSURED: _____ DOB_____

GROUP #: _____ MEMBER ID / POLICY # _____

INSURED'S RELATIONSHIP TO PATIENT _____ PHONE # (_____) _____-_____

EMERGENCY CONTACT **RELATIONSHIP TO PATIENT** _____

LAST NAME _____ FIRST NAME _____

ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____-_____ WORK PHONE (_____) _____-_____

PRIMARY CARE PHYSICIAN (PCP) OR FAMILY DOCTOR _____

ADDRESS _____ PHONE (_____) _____-_____

IF APPLICABLE, THE NAME OF THE DOCTOR WHO REFERRED YOU _____

ADDRESS _____ PHONE (_____) _____-_____

REASON FOR TODAY'S VISIT _____

_____

Southwest Nephrology Associates, L.L.P
7777 Southwest Freeway, Suite 304
Houston, Texas 77074

Medical History Questionnaire

Patient _____ Date of Birth _____

Instructions:

- *Please complete the form below*
- *This form will be used to screen any conditions that you may have*

CONDITIONS: Circle YES or NO as applicable

Condition	If yes, please describe in next column.	Description/Comment	Start date	Ongoing? Is condition still present? Circle YES or NO below.	Stop date - If condition no longer exists, give stop-date.
Kidney Disease	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Diabetes	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
High Blood Pressure	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Ischemic Heart Disease/ Heart problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Cancer	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Stroke	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Gout	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
ENT- Head/Ear/ Nose/ Eye/ Throat/ Mouth problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Cardiovascular- High Cholesterol/ Pacemaker/Valvular heart disease	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Respiratory- Pneumonia/ COPD/ lung problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Gastrointestinal- liver/ hepatitis/ stomach problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /

Medical History Questionnaire

Patient _____ **Date of Birth** _____

CONDITIONS: Circle YES or NO as applicable

Condition	If yes, please describe in next column.	Description/Comment	Start date	Ongoing? Is condition still present? Circle YES or NO below.	Stop date - If condition no longer exists, give stop-date.
Genitourinary- UTI/ Kidney Stones	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Musculoskeletal- Arthritis/ rheumatism/ Osteoporosis	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Neurological- Epilepsy, Seizures, Dementia problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Psychiatric- Depression/ Anxiety Disorders	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Endocrine- Hypothyroidism/ Hyperparathyroidism	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Hematology- Anemia/ Blood disease	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Immuno/Allergy- HIV AIDS/ LUPUS	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Prostate problems	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /
Others	Yes No		/ /	Yes No	/ /
			/ /	Yes No	/ /
			/ /	Yes No	/ /

SURGERIES / HOSPITALIZATIONS: ☐ **None**

Date	Surgery and Hospitalizations
/ /	
/ /	
/ /	
/ /	
/ /	
/ /	

SOCIAL HISTORY

Tobacco	Alcohol	Caffeine
__ Never Used __ Ex-user __ Currently use	__ Never Used __ Ex-user __ Currently use	__ Never Used __ Ex-user __ Currently use
Start date _____/ ____/_____ Stop date _____/ ____/_____	Start date _____/ ____/_____ Stop date _____/ ____/_____	Start date _____/ ____/_____ Stop date _____/ ____/_____

# cigarette Packs / day _____ # cigars / day _____ # pipefuls / day _____ # patches / day _____	Beer: # cans / week _____ Wine: # glasses / week _____ Liquor: # drinks / week _____	# ounces / day _____

DRUG USE

☐ Never used ☐ Ex-user

Have you used illicit or recreational drugs in the past 12 months?
__ No __ Yes If yes, date last used: ____/ ____/ _____

Is there a Family history of:

Kidney Disease? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
Diabetes? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
High Blood Pressure? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
Ischemic Heart Disease? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
Cancer? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
Stroke? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
Gout? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
ADPKD?(adult polycystic kidney disease) ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child
Dementia? ☐ **None**	☐ Father ☐ Mother	☐ Sibling ☐ Child

Status:

Father: ☐ **Living** ☐ **Deceased** ☐ **Unknown** **Age of Death:_____** **Cause of Death:_____**

Mother: ☐ **Living** ☐ **Deceased** ☐ **Unknown** **Age of Death:_____** **Cause of Death:_____**

MEDICATIONS: What over-the-counter, herbal remedies or prescription medication do you take? Or ☐ None

Medication	Dose	# times/ day	Reason	Start Date	Ongoing? Are you still taking this medication?)	Stop date (If not, when did you stop?)
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /
				/ /	__ Yes __ No	/ /

Pharmacy Name/ Location: _____ **Pharmacy Phone Number: _____**

Southwest Nephrology Associates, LLP
NEPHROLOGY & DIALYSIS

Main Office: 7777 Southwest Freeway, Suite 304, Houston, TX 77074 | Tel 713.270.4545 | Fax 713.270.9197

Patient Name: _____ DOB :_____

QUESTIONNAIRE

- Do you have an Advance Care Plan set for end-of-life decisions such as a living will or Power-of -Attorney?
  ☐ YES ☐ NO

  if YES; please provide name of surrogate decision maker:_____
  (If you have a copy of the Power of Attorney please provide a copy to our staff.)

  - Would you like a General Information form of Durable Power of Attorney? ☐ YES ☐ NO

- In the past year, has another doctor checked your blood for Lipids (cholesterol)?
  ☐ YES ☐ NO
  if YES; please provide name of doctor _____

- This only applies to diabetic patients: has another doctor checked you blood for A1c? ☐ YES ☐ NO
  if YES; please provide name of doctor _____

- Have you received a flu shot? (seasonal October 1- March 31)
  ☐ YES ☐ NO
  if YES; please provide when and where (provider name or facility)_____

- When was the last time you received the Pneumococcal Vaccine? _____

- If you would like patient electronic access, please provide an email address: _____
  (you only have 3 days from date of appointment to activate patient portal)

Southwest Nephrology Associates, LLP
NEPHROLOGY & DIALYSIS

Main Office: 7777 Southwest Freeway, Suite 304, Houston, TX 77074
Tel 713.270.4545 | Fax 713.270.9197

HIPAA Release Form

Patient: _____ Date of Birth: _____

RELEASE OF INFORMATION

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] I do not authorize the information to be released to anyone.

MESSAGES

Please call: [ ] my home [ ] my work [ ] my mobile number: _____

If unable to reach me: [ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

I am fully aware that a cell phone is not a secure and private line.

Signed: _____ Date: _____